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CONTENTS

HEART DISEASE AND PREGNANCY*

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Heart disease complicated by pregnancy is a problem that vitally concerns the obstetrician and the cardiologist. The decision as to what should be done regarding pregnancy in a given woman with serious heart disease requires a considerable nicety of judgment. It is true that the individual physician does not see many such patients and it is because of this rarity that opinions, in the past, have varied as to the proper method of handling such cases.

Within the past ten years closer coöperation between the obstetrician and the cardiologist, and the study of statistics, particularly in the larger clinics, have established certain definite principles to guide us. A wide diversity of opinion still exists regarding many of the more detailed features.

It has been estimated that in the average hospital about 7.5 per cent of the pregnant women show something in their history or physical examination to suggest heart disease. Of these, about one in seven or 1 per cent of all pregnant patients, have seriously damaged hearts. On the other hand when we realize that only a few years ago in the larger Boston hospitals 15 to 25 per cent of the total maternal mortality was due to heart disease, we appreciate the importance of this complication. In these same institutions today this percentage has been reduced to about ten.

We must realize that our present statistics

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are not entirely accurate in that our figures are largely concerned with the patient up until the time she leaves the hospital. We have little information as to how long her compensation is maintained afterwards.

The problem is usually presented in one of three ways:

1. Shall the woman with heart disease marry?
2. Shall the married woman with heart disease become pregnant?
3. Shall the married woman with heart disease continue her pregnancy, and if not, when should it be terminated?

As a rule the same considerations apply as to whether the patient should marry, as when married whether she should become pregnant. Improved antenatal care has done much to pick out the serious cases and institute rational treatment early. In spite of this it is the third question that we are called upon to answer to often. Some women are advised against marriage and pregnancy, and disregard the advice. Many are not seen until pregnancy is well advanced and congestive heart failure is present.

In a study of this problem, one requisite is an understanding of the changes that take place in the cardiovascular system during a normal pregnancy. It has been shown that the blood flow per minute is increased 30 to 50 per cent in the later months of pregnancy. This is attributed to the new demands made on the circulation by the increased body weight, the enlarged placenta, and the increase in the size of the breasts.

As the tumor increases in size it tends to obstruct the free movement of the diaphragm, displace the heart, change the shape of the chest, and compress the bases of the lungs.

There is considerable difference of opinion as to whether the heart enlarges during normal pregnancy. Sir James McKenzie felt that it did not. Because of the change in position and contour of the organ during pregnancy it is difficult to arrive at a final answer to this question.

Shortness of breath, palpitation, tachycardia, and edema of the feet are not unusual, specially in the later months of normal pregnancy. These symptoms are definite evidence of an additional burden on the circulation. Systolic murmurs, especially over the mitral and pulmonic areas, are not uncommon. These disappear, as a rule, during the first four weeks following delivery, and should not be confused with organic murmurs. Symptoms vary with the usual response of a particular individual to physical exertion. If these facts are kept in mind, confusion should not occur regarding the normal heart during pregnancy.

Patients showing abnormal cardiac signs and symptoms may, for the purpose of discussion, be divided into three groups:

1. Neurocirculatory asthenia.
2. Doubtful heart disease.
3. Significant heart disease.

The first group consists of those individuals complaining of breathlessness, syncope, tachycardia, precordial pain, and weakness. They are nervous and often constitutionally inferior individuals in whom no organic heart disease can be found after careful examination, including x-ray and the electrocardiogram. This condition has been termed neurocirculatory asthenia, irritable heart, soldier's heart, or effort syndrome. These patients do not need specific cardiac treatment, but need reassurance, careful management, and psychotherapy.

The second group contains those patients with slight or questionable cardiac enlargement; loud systolic murmurs, commonly in the mitral area; or an irregular rhythm that proves to be sinus arrythmia or extrasystoles. They are without symptoms as a rule, and have a good response to effort. After a thorough study we do not feel justified in classifying them as having definite organic heart disease. These patients do well during pregnancy and can be disregarded as far as special treatment for the heart is concerned.

In the third group I have included all patients with organic heart disease, and have subdivided them as follows:

1. Rheumatic heart disease.

(a) Recent or active rheumatic fever.

(b) Valvular lesion, sinus rhythm, with normal sized heart.

(c) Valvular lesion, heart enlarged or greatly enlarged, rhythm regular or irregular.

2. Luetic heart disease.
3. Congenital heart disease.
4. Paroxysmal tachycardia.
5. Subacute bacterial endocarditis.
6. Thyroid heart disease.
7. Acute carditis.

8. Degenerative heart disease.
9. Angina pectoris.

Ninety per cent of the pregnant women with significant cardiac pathology have rheumatic heart disease, and the majority of these have mitral stenosis. Some have a combined mitral and aortic lesion, and a few have an aortic lesion alone. Most of our discussion will refer to this group of cases. Brief specific mention will be made of the various other types of heart disease that may occasionally complicate pregnancy.

Acute rheumatic fever contraindicates marriage and pregnancy for one year after the attack. If it occurs in the early months of pregnancy, and the heart is seriously involved abortion is justified; if in the later months, the patient may be carried along with bed rest and salicylates until a viable child is obtained.

Until twenty years ago, and even yet in some text books, the opinion is expressed dogmatically that patients with mitral stenosis should not marry; if they are married should not become pregnant; and if pregnant should have a therapeutic abortion and sterilization performed. This opinion is not generally accepted today, and I am sure that all of us have seen patients with mitral stenosis go through one or more pregnancies without complications or aggravation of the heart condition which was demonstrable.

Due to the natural evolution of the disease, the life of the young woman with rheumatic heart disease is materially shortened. The average length of life for patients with mitral stenosis is about forty years. The degree of the stenosis, learned by a careful examination of the mitral murmurs; the resulting enlargement; and the degree of associated myocarditis will alter the prognosis as regards life, as well as our opinion as to whether pregnancy should take place or continue. The nervous make-up of the patient is important. The calm, lethargic type does better and is apt to bear marriage and pregnancy better than the hyperkinetic woman. The economic status of the patient may be the deciding factor in allowing pregnancy. If the prospective mother can have someone to assist her constantly during pregnancy and the postpartum period, the chances of difficulties arising, related to her heart, are greatly lessened.

Some writers consider aortic insufficiency more serious than mitral stenosis. It is much less common. If it complicates a mitral stenosis, of course it adds to the gravity of the lesion. Sir James McKenzie felt that pregnancy could be allowed with safety in patients with aortic insufficiency, in the absence of a Corrigan pulse and marked cardiac enlargement.

The consensus of opinion today may be summarized by stating that in all cases of rheumatic heart disease the patient may be allowed to marry and become pregnant if the heart is not enlarged, the response to effort is satisfactory, there is and has been no congestive failure, and the rhythm is regular. On the other hand, if there is a clear history of congestive failure, auricular fibrillation or flutter, if the mitral stenosis is advanced and accompanied by a large heart, or if there is aortic insufficiency with a Corrigan pulse and hypertrophy, a definite veto must be given.

It is the borderline cases that give the most difficulty in arriving at a decision. Thus, a woman may have a fairly tight stenosis, some cardiac enlargement, and moderate limitation in her response to effort. She and her husband may be very eager to have a child. In such cases, the functional rather than the anatomic condition is our best guide. Often the deciding factors are apart from the heart itself. The lives of some of these women could be unbearable without children, and in such cases the patient is entitled to know to what extent the usual dangers of pregnancy are increased by her cardiac lesion. She, or a reliable relative, should be advised that if pregnancy is allowed she takes a 5 per cent risk during pregnancy and the puerperium, and a 10 per cent risk of having a dead baby. To keep the above risks at a minimum she should be prepared to carry out the physician's orders explicitly and be ready at any time to enter a hospital and agree to interruption of pregnancy if necessary.

If the patient is seen during the first three months of pregnancy, a decision as to whether the pregnancy should be allowed to proceed may be based on the same factors that have decided us in regard to permitting pregnancy. Thus, if the heart is not enlarged, the response to effort satisfactory, the rhythm regular, and there has been no congestive failure, the pregnancy may continue. Chronic passive congestion, auricular fibrillation, and a very large heart with

limited cardiac reserve, indicate therapeutic abortion and sterilization. In the borderline cases, if the patient's heart is the primary consideration, we are well advised to produce an abortion. If however, the woman is prepared to face the ordeal we must do all we can, and we can do a great deal, to minimize the dangers of pregnancy and parturition by constant supervision, and prompt and effective treatment, both medical and surgical.

When the pregnant woman is not seen until after the fourth month, suitable treatment is outlined in an effort to obtain a viable child. This is necessary, not only from the standpoint of obtaining a living baby, but because induced labor at this time is considered just as dangerous, as far as the heart is concerned, as if the patient were given suitable treatment and allowed to continue to or near term.

Once the pregnancy has been allowed to proceed, each one of these patients should be under close supervision. They are all candidates for auricular fibrillation or subacute bacterial endocarditis, and such complications may bring on congestive heart failure.

Such early signs of insufficiency as râles at the lung bases, rapid respirations, duskiness of the face, increased pulse rate, and hemoptysis should be watched for carefully and receive immediate treatment if they appear. Embolism may occur but is not more common in pregnancy than in the non-pregnant patient with rheumatic heart disease.

Conditions other than rheumatic heart disease constitute about 10 per cent of the cardiac pathology in pregnant patients. A variety of etiological factors make up this small group and hence any one factor is not commonly active. It is well known that patients with leutic heart disease, especially those with aortic insufficiency, do not do well. After congestive heart failure has developed the average length of life is about two years. The condition is not always incompatible with childbearing, however, and some of these women produce living children. Marriage and pregnancy should be vetoed, but if the patient who is pregnant has a good response to effort and there has been no congestive failure, the pregnancy may be carried along under close supervision and a living child obtained in a few cases. In the interests of both mother and child antiluetic therapy should be carried out, observing the same caution as in all cases of cardiovascular lues.

Congenital heart disease is relatively rare in pregnancy. Sir James McKenzie felt that those patients who reach the age of twenty-one without undue symptoms, in whom cyanosis and clubbing are absent, and who show little cardiac enlargement might be allowed to continue pregnancy without great risk.

We occasionally see patients with short periods of paroxysmal tachycardia occurring infrequently. Marriage and pregnancy need not be prohibited in these cases. If the attacks are frequent and of long duration, pregnancy should be delayed or postponed indefinitely. Therapeutic abortion may be indicated in the early months of pregnancy in such patients, and if the child is viable the delivery should be postponed until the paroxysm is under control. If the attacks are ventricular in origin, the condition is more serious and usually contraindicates both marriage and pregnancy.

Subacute bacterial endocarditis is more commonly seen during the later months of pregnancy, at delivery, or during the puerperium. All patients with chronic valvular disease, especially of rheumatic or congenital origin, are prone to develop this condition. This tendency seems to be increased by pregnancy. Hay, in England in reporting his cardiac mortality during pregnancy, attributed 28 per cent to this complication. The prognosis in a true case of subacute bacterial endocarditis is almost without exception fatal. The condition prohibits marriage and pregnancy and indicates abortion in the early months. If the patient is not seen until after the fourth month, and the endocarditis is fairly well advanced, it is likely that miscarriage will occur. In a few such cases a living child may be obtained. At delivery, or in the puerperium it is not always easy to establish the diagnosis of subacute bacterial endocarditis. These patients will have the usual heart murmurs associated with chronic valvular disease, fever may be present, and streptococcus viridans is not uncommonly obtained from the blood stream. Continued observation is necessary in such cases and it is a mistake to suggest the hopeless prognosis usually associated with subacute bacterial endocarditis until the diagnosis has been further substantiated by the appearance of emboli, enlarged spleen, and other manifestations of the disease.

The question of thyroid disturbance in pregnancy presents an entire topic in itself. Every obstetrician is aware of the deleterious effect of hypothyroidism on both the mother and the child. The generally lowered metabolism at times seriously handicaps the heart. Fortunately, in such cases the judicious use of thyroid extract will control the condition and restore the cardiac reserve. Hyperthyroidism is not uncommon in pregnancy. Many mild cases probably go to delivery with return to normal post partum without a diagnosis having been made. In the more severe case the hyperthyroidism should be treated as in the non-pregnant woman.

Outside of the rheumatic and luetic groups, acute myocarditis is rarely seen, even when not associated with pregnancy. Occasional cases do occur, however. In such cases the electrocardiogram is of considerable aid in diagnosis. Pregnancy is contraindicated in these individuals until one year at least after the acute condition subsides.

Degenerative heart disease is uncommon in women of child-bearing age, and when present is commonly associated with arterial hypertension and nephritis. The latter conditions of themselves contraindicate pregnancy and such women should not be allowed to become pregnant, especially in the presence of complicating heart disease. Therapeutic abortion should be done early in such cases.

Angina pectoris is occasionally associated with luetic and rheumatic heart disease, and if present adds to the seriousness of the lesion. It may occur with or without the hypertensive cardiovascular syndrome. If the attacks are frequent or severe, pregnancy is contraindicated.

TREATMENT

The question of treatment is in part at least inseparable from consideration of the problem as a whole. Certain features regarding the management of these patients will be discussed in detail.

When we have decided that a patient has significant heart disease, but have allowed marriage and pregnancy, close supervision of the cardiac status is indicated. The amount of physical exercise allowed will depend on the severity of the heart condition. In the absence of congestive failure these patients need exercise, and walking is the best form if kept within the limits of fatigue. Light housework is permitted, but climbing stairs, shopping, and heavy work should be avoided. Help in the home is essential, especially for the more severe cases. These women should have ten hours rest each night, should eat small meals, and rest at least one-half hour after each meal. Precaution should be taken to avoid infection, and even with the common head cold bed rest should be carried out until recovery is complete. Those patients with less severe heart disease should be seen every two weeks and the more severe cases every week to watch for complications and evidence of cardiac insufficiency.

If congestive failure develops in the first three months of pregnancy, the patient should be put on bed rest with fluids and salts restricted, and digitalis given to its full therapeutic effect. When the insufficiency has cleared up therapeutic abortion should be done. If the patient will agree, sterilization should be done at the same time. The particular method of doing this will vary in different individuals and with the skill of the operator. In multipara, frequently the uterus can be emptied and the tubes tied per vagina. In primipara, miniature cesarean section and sterilization by the abdominal route is often the method of choice. Morphine and light ether anesthesia have proven entirely satisfactory in such cases, although more recently low spinal anesthesia is becoming more popular.

If the patient reaches the fourth month satisfactorily every effort is made to continue the pregnancy until the child is viable. If treatment is carried out faithfully most of the less severe cases will go to term and be delivered without difficulty, perhaps with the aid of forceps during the second stage. The manner of delivery in those patients with more serious heart disease has led to much discussion and is as yet a controversial subject. Each case is a problem in itself. Premature labor occasionally occurs while the case is under consideration and so settles the argument. It is generally agreed that there is little advantage in inducing labor before the thirty-sixth week. A few writers consider induction of labor more serious than delivery at term. However, in the majority of instances termination of the pregnancy two to three weeks before the estimated date of confinement is advisable.

There is no unanimity of opinion as to the ideal way of emptying the uterus. It is generally agreed that cesarean section produces less strain on the heart than delivery per vagina, and also furnishes an opportunity for sterilization. On the other hand, there is the additional risk of respiratory and other post-operative complications. The skill of the operator and the facilities at hand are important factors in deciding the individual problem. In the average clinic the majority of multipara and a few of the primipara are delivered per vagina. Cesarean section is used for patients in whom treatment will not clear up the congestive failure, for obstetrical reasons, and in a rather large percentage of primipara when sterilization is agreed upon.

If suitable coöperation is obtained from the patient and proper observation given by the physician, a patient need rarely be delivered while in congestive failure. Pardee goes so far as to say that delivery in failure is an evidence that someone has blundered.

Unfortunately the education of the public has not reached the stage in which all women apply for prenatal care, and a number of women do not consult a physician until late in pregnancy when congestive failure has developed. A few also, even under satisfactory coöperation and observation, develop intractable failure, due to the development of fibrillation, embolism or bacterial endocarditis.

In all cases it is extremely dangerous to deliver a patient during heart failure in any stage of pregnancy, particularly in the later months. The heart failure needs treatment first, and every effort should be made to get the patient into as good condition as possible in the time intervening before labor is due. If possible it is a good plan to keep these women in a hospital or under hospital conditions until delivery. It is, of course, a mistake to keep such patients in bed longer than two or three weeks after the congestive failure has cleared up. Normal exercise within limits of fatigue and under close supervision is beneficial rather than harmful. If improvement is not obtained after three weeks of treatment the chances of the patient going to term, and especially of obtaining a living child are small. In these patients cesarean section with sterilization is indicated. The mortality in such cases is unfortunately very high.

If such patients are not seen until after labor has begun, and sedation with morphine does not interrupt the pains, cesarean should be done if the head is high, and forceps used if it is low.

In paroxysmal tachycardia, fibrillation, and flutter it is obviously clearly desirable to avoid emptying the uterus until suitable therapy is given.

If a patient recovers from one attack of insufficiency and it recurs later in the pregnancy, experience has shown that further treatment offers little chance of restoring compensation a second time. In such cases the uterus should be emptied at once.

Regardless of how well the patient appears to be before delivery, preparation should be made for all emergencies. If there is a history of failure it is wise to digitalize the patient. Oxygen should be available and used early if needed at all. Interstitial saline, a venesection outfit, and loaded hypodermic syringes should be within easy reach. The extremely flat position of the delivery table is often distressing to the patient, and the head and shoulders should be elevated.

The actual delivery of the child should not be too hurried, and care should be taken to maintain the intra-abdominal tension by manual pressure on the abdomen, as a sudden release of pressure may cause severe surgical shock and collapse. If there is much cyanosis and congestion of the lungs it is helpful to allow bleeding to go on freely as this is equivalent to a slow venesection, and relieves the load on the right side of the heart. In any case ergot and pituitrin are contra-indicated at this time. Venesection proper should be done if pulmonary edema occurs; and morphine and atrophine administered. No undue haste should be exhibited in attempting to express the placenta. Morphine and atropine are useful after the placenta has been expelled.

There is considerable difference of opinion as to the choice of anesthetics. Probably the skill of the anesthetist is a more important factor than the type of anesthetic used. It is generally agreed that ether during the second stage is entirely satisfactory. Sodium amytal is not applicable due to the tendency to excitement during the recovery stage. Hermann feels that a general anesthetic is contra-indicated in bundle-branch block, fibrillation, syphilitic aortitis, angina pectoris, and high grade congestive failure. He

advises either local or spinal anesthetic. A few writers, particularly the English, feel that spinal anesthesia is unsafe because of the tendency toward a rapid fall in blood pressure. In this country, however, this method seems to be gaining an increasing number of advocates.

In heart disease relief is not obtained immediately after delivery as is so commonly the case in eclampsia. For the first twenty-four hours the patient must be watched carefully. She may collapse and die soon after the uterus is emptied. Very careful observation should be extended to daily visits during the first two weeks after delivery, because not infrequently a break occurs late in the puerperium, after the danger seems to have passed. The patient should be kept strictly in bed for one month after delivery.

The infant mortality varies from ten to thirty per cent. The question as to whether the mother should nurse her baby depends on social as well as physical circumstances, but as a general rule it is permissible.

SUMMARY

1. A more generalized dissemination of knowledge regarding the importance of heart disease in pregnancy will bring women to the physician early and thus obviate to a large extent the necessity of delivery in the presence of congestive failure with its resulting high mortality.

2. A careful diagnosis will separate these patients with significant heart disease from the doubtful or non-organic cases. The significant cases may then receive early and proper protection, and the others the reassurance that their ordinary activities need not be curtailed.

3. Patients who have had congestive failure, auricular fibrillation, or a large heart with aortic and mitral lesions, singly or combined, especially if their response to effort is poor, should be advised against marriage and pregnancy. If seen early in pregnancy, therapeutic abortion and sterilization should be done.

4. If the patient is not seen until after the fourth month, the pregnancy should be allowed to continue until a viable child is obtained. No method of delivery is applicable in all cases. Each one must be judged on its individual merits; the skill of the obstetrician, and the facilities which are available. often being the deciding factors.

5. The uterus should not be emptied in the presence of congestive failure. This must be treated first and the pregnancy considered later.

6. These cases should not be viewed in too gloomy a light. Many go through pregnancy without difficulty. In questionable cases, the functional rather than the organic condition of the heart should be the deciding factor.

7. We can improve our judgment on this problem by a more careful follow-up of these patients months and years following delivery as there is very little reliable information on this subject at the present time.

FILAMENT - NONFILAMENT COUNT IN CHRONIC ARTHRITIS: AN AID IN THE DIFFERENTIATION OF RHEUMATOID ARTHRITIS AND OSTEO-ARTHRITIS

In their studies of the chronic rheumatic diseases OTTO STEINBROCKER and EDWARD F. HARTUNG, New York, resorted to various aids to facilitate the diagnosis and differentiation of chronic rheumatoid arthritis and osteo-arthritis. Because infection is considered the etiologic factor in some forms of these diseases, they have for some time sought diagnostic assistance from the study of the blood picture. They observed that the filament-nonfilament count is a useful routine diagnostic aid in chronic arthritis. Filament-nonfilament counts in fifty patients with rheumatoid or chronic infectious arthritis were abnormally elevated in 100 per cent of the patients. The filament-nonfilament count was normal in twenty-six patients, or 52 per cent, of a group of osteo-arthritic patients, while in the rest of this group the count was elevated. The average nonfilament count was much higher (31.5 per cent) in patients with rheumatoid arthritis than in osteo-arthritic patients with an abnormal count (22.3 per cent). The filament-nonfilament count is helpful in differentiating rheumatoid arthritis from osteo-arthritis only when within normal limits. A normal count indicates that chronic rheumatoid infection is not present. An elevated count may indicate the presence of rheumatoid arthritis, mixed rheumatoid and osteo-arthritis, or osteo-arthritis with active focal infection.—*Journal A. M. A.*

A REVIEW OF THE DIETARY TREATMENT OF PSORIASIS

INCLUDING A BRIEF DISCUSSION OF A POSSIBLE ENDOCRINE ETIOLOGY

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Psoriasis, as well as all other diseases, has received its quota of attempted cures by various forms of diet and it is still a question of debate by eminent dermatologists whether diet alone or combined with other methods of treatment is of value in the control of this refractory disease.

As far as diet and metabolic studies in psoriasis are concerned they appear to be so closely interwoven that it might be well to briefly mention the most recent work done along those lines.

In 1913 Schamberg[20] and his associates began a thorough and systematic investigation of the question of psoriasis and found a definite nitrogen retention in the series of cases then reported. This retention occurred even when the nitrogen intake was smaller than that necessary to maintain the nitrogen equilibrium. At that time he advocated the limitation of nitrogenous food to an extremely low point and stated he did not claim that food was the cause of psoriasis but "that low protein diet, without any other internal or external treatment, did cause a disappearance of the greater part of the eruption." It was also found that the skin would later tolerate remedies which it could not tolerate before the dietary treatment.

At various times since then Schamberg and his co-workers have reported their findings in their investigations. In 1924[21] no disturbance of purin bodies was found.

In the same year[22] he discussed the etiology from the standpoint of rheumatism (infection), renal defects, defective food assimilation, pancreatic disease, digestive and nutritive disorders, disturbance of the nervous system, tuberculosis, syphilis, endocrine changes, parasites and metabolism.

In 1930 these investigators[23] reported that they found no material change from the normal with regard to the inorganic constituents of the blood—calcium, magnesium, potassium and phosphorus.

There is the possibility that there may have been a dietary fault in the cases investigated by Fleisher and Wachowiak[4] in 1925 in which they found monilia or monilia-like organisms in 82 per cent of feces, 21 per cent in the blood and 46 per cent in skin scrapings. In normal individuals 6 per cent of stools were positive, but no monilia were found on normal unexposed skin or in the blood.

Their findings, however, would appear to be negatived by the recent report of Torrey and Schwartz.[26] These writers found that the types of bacteria in the stools of psoriatics did not differ materially from those found in the stools of non-psoriatics, nor did they find any unusual number of yeasts, moniliæ, when found, being only in small numbers. Their blood cultures were also essentially negative, nor was any evidence of sensitization of an allergic nature found to test bacteria isolated from the blood or stools.

Carillon[2] in 1926 regarded the pathogenesis of the disease as being on a sympathetic-endocrine base with changes in the sympathetic tonus. The derangement of metabolism of the epidermal cells, followed by irritation of trauma or infection, increased the desquamation of the skin resulting in psoriasis.

Throne and Myers[25] found no nitrogen retention in 35 cases reported and recommended sodium thiosulphate in those having a high blood sugar and low chloride content.

Hufschmitt[9] in 1931 thought an excess of phosphorus might influence the lesions in spite of finding the blood calcium and phosphorus normal. Administration of these salts gave negative results.

Acting on the theory of a tuberculous origin for psoriasis, Nicholas, Mollard and Lebeuf[16] treated twenty cases with gold salts, reporting seven cases in which the lesions disappeared, eight with no improvement.

In accordance with the known clinical ef-

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fect of fevers on psoriasis, Gougerot[6] reported two cases in which the lesions disappeared after high temperatures—one case due to anthrax, the other induced pyrexia.

Michon[13] reported the effect of thymus extract subcutaneously in a patient who had a coexisting psoriasis and hyperthyroidism. Both diseases responded promptly to the treatment.

In Keller's case[10] of psoriasis arthropathica the psoriasis appeared six months after thyroidectomy in a woman of thirty. Ovarian extract improved the conditions but the psoriasis did not entirely disappear.

In 1925 Hendrie[8] reported a few cases treated with parathyroid extract but no improvement was noted.

Hedge[7] in 1931 stated his belief in a relationship between psoriasis and a deficiency of calcium as regulated by parathyroid hormone. He further believed that the disease might be produced by the inhibiting influence of tuberculosis, syphilis or other gland-affecting disease, thus depriving the blood-forming mechanism of that part controlling calcium regulation. In the same manner diet and gastrointestinal disease may be instrumental in the production of psoriasis.

In accordance with his belief he thought that the treatment of psoriasis should strive to return the secretions of the parathyroid glands to normal, supply the calcium in form and quantity sufficient for organic needs and correct such other pathologic changes as may be present.

Burnett[1] reported cases cured or improved by correction of diet and malabsorption. These cases all had definite dietary faults and there is no evidence to support a claim of cure for any of these cases any more than for any other method which successfully causes lesions to disappear.

Rowe[18] in "Food Allergy" considers there is a possibility of psoriasis being a manifestation of allergy. He mentions three cases with psoriatic lesions accompanied by symptoms of food allergy, the dermal lesions improving with control of the allergic state.

Levin and Silvers[12] obtained encouraging results with a salt-free diet, an abundance of vegetables and fruits, sweat baths and oily applications.

Haldin-Davis[3] questions whether psoriasis is a result of a retardation of the oxidative processes of the skin. He refers to the report of Gans in finding a tendency to acidity in psoriatic areas.

Gans[5] gave ammonium chloride to psoriatics with an increase in the number and severity of the lesions and concluded that the result indicated a disturbance of the normal acid-alkaline balance.

In Spillman's[24] report in 1931 Gans findings were not substantiated.

Monash[15] found that psoriatic lesions involuted more rapidly by the use of viosterol and the usual antipsoriatic remedies. Those especially benefited were those improving with sunlight and ultraviolet therapy.

In Schamberg's[19] latest article he expresses surprise that the profession has received with so little enthusiasm and confidence the conclusions that he and his coworkers had reached a few years ago. He reiterates his statement that he does not consider food to be a cause of psoriasis but "a low protein diet without any other internal or external treatment did cause a disappearance of the greater part of the eruption."

He reports two cases (with photographs) to further substantiate his claim that diet control can cause psoriatic lesions to disappear. This action he explains on the ground that the rapidly proliferating and exfoliating epithelial cells are deprived of the protein they require to stimulate their growth.

He also gives in detail two diets low in nitrogen—each under 5 grams of nitrogen daily—and has never observed any harm from keeping a patient on a low protein diet for months at a time. There should be, however, sufficient calories to maintain the patient's body weight.

In order to further evaluate the low protein dietary treatment in psoriasis, a questionnaire was sent to a number of leading dermatologists to obtain their results in the use of this method.

Of forty-nine replies twenty-three reported no success; eleven had no faith in any form of diet as a cure for psoriasis; fifteen believed that some form of diet was beneficial in certain types of cases but that the dietary change might be either nitrogenous or carbohydrate depending on the case. Several also believed that acute cases were more readily controlled by reducing the protein.

In fairness to this method of treatment it should be stated that a number who reported no success admitted that the patients had not been hospitalized and probably had not had the diet rigidly supervised. The greatest objection seemed to be that it was not well

suited for any except hospitalized cases and therefore not practical.

All who had had any success with diet were agreed that it was of little or no value to place the dietary limitations in the patient's own hands with the recommendation to "cut down on meat, butter, eggs and milk."

One report stated good results in hospitalized cases either with or without a low protein diet. One mentioned a patient who became worse on the diet but improved with meat. Several regularly reduced the nitrogenous intake.

With all the mass of varied and often conflicting evidence regarding the value of diet in psoriasis, the changes in the inorganic salts of the blood, the reported cures (?) by numerous methods, endocrine extracts and others, can we weigh correctly the evidence and arrive at some definite conclusion?

To judge the evidence impartially one must conclude that in certain cases dietary changes have a favorable influence in psoriasis, but as food is not regarded as a cause of psoriasis, improvement might follow although a cure could not be expected.

It is also conceivable that all the work reported is gradually linking all the various factors noted in the behavior of psoriasis to the control of the process of keratinization by an endocrine hormone.

The following questions were asked of an endocrinologist:

1. What effect would a low nitrogenous diet have on the pituitary or other endocrine function?
2. If such effect occurred what would be the mechanism of the production of skin changes?
3. Could septic absorption produce endocrine changes that might result in skin lesions of psoriatic type?

The following letter was received in reply:

Dear Doctor Jamieson:

In answer to your letter of June 20 and the questions therein:

1. Dr. B. A. Houssay of Buenos Aires deserves credit for showing the influence of the pituitary on general metabolism.

Dr. Houssay stated that the anterior lobe has a regulating effect on the general metabolism. Insufficiency of the anterior lobe diminishes, while hyperfunction of that body increases the basal metabolism. The hypophysis stimulates the endogenous protein metabolism as well as the fixation of protein in the tissues, thus explaining the overfunctioning of the pituitary body in the development of acromegalia and gigantism. The endogenous protein metabolism, more than the exogenous, is under the influence of the pituitary body. Pituitary insufficiency diminishes the destruction of protein in the tissues such as is seen during fasting and in phlorizin diabetes and pancreatic diabetes. The creatinine elimination, which is the index of endogenous nitrogen metabolism, is lower in dogs deprived of both pituitary and pancreas than in dogs in which the pituitary and not the pancreas has been removed, even though the latter receive meat in their diets. Hypophysectomized dogs frequently have hypoglycemia which may be fatal if not controlled by administration of sugar. Houssay concludes that animals deprived of the pituitary form less sugar at the expense of the endogenous proteins than normal animals do. The pituitary, by its stimulating effect on the consumption of endogenous protein, also has an effect on the transformation of such protein into sugar.

Credit for the above remarks should go to Dr. Houssay. Consequently, a low protein diet would slow up the pituitary and naturally general metabolism.

2. If such effect occurred what would be the mechanism of the production of skin changes? One could understand from this that the lessening of the pituitary function would produce chemical changes in the mesodermal corium of such a nature as to permit the clearing up of the psoriasis lesions. Naturally the specific chemical changes are, as yet, unknown.

3. Could septic absorption produce such endocrine changes that might result in skin changes of psoriatic type? One could readily understand that septic absorption with toxemia would, of course, stimulate protein metabolism, which in turn stimulates the pituitary funciton. One can also see that anything that stimulates metabolism would also have a tendency to stimulate grandular function.

My personal opinion concerning the pituitary function is that it affects mesodermal tissues including the mesodermal corium.

Yours sincerely,

ROBERT C. MOEHLIG.

It would appear from these answers that dietary faults, of whatever type, provided they stimulate protein metabolism, would be capable of influencing the changes necessary for the production of psoriasis. The same would also be true of focal infections. If, then, either or both of these factors were present, might not endocrine changes occur which would allow the rapid proliferation of epithelial cells and the production of psoriasis?

In this connection it is interesting to note several articles by foreign writers.

Walinski[27] treated six patients with anterior pituitary extract, all of whom responded to this method. He believed from his results that psoriasis is etiologically related to an endocrine disturbance.

Leszcynski[11] also believes some glandular disturbance is back of the etiology of psoriasis as he found Chvostek's sign in 22 per cent of his cases. (Chvostek's sign—a sudden spasm on tapping one side of the face: seen in post-operative tetany—indica-

tive of glandular (parathyroid) insufficiency.)

In 1927 Rochlin, Schirmunsky and Kotschneff[17] made a report on the results obtained from irradiation of the hypophysis for the treatment of psoriasis. Of sixteen cases treated three showed complete resorption of the lesions, improvement beginning within 14 days following the treatment; one case was noticeably improved; in three the exfoliation was diminished and in the remaining cases no change was noted.

These results compare with those obtained by irradiation of the thymus gland.

In a recent article Moehlig[14] goes extensively into the embryo hormonic relation of the endocrine glands and discusses the interdependence of the thyroid and pituitary bodies. He states "The involvement of the ectodermal pituitary glands results in secondary mesodermal tissue involvement, not, however, to the extent seen in primary pituitary changes. Likewise it must be remembered that the age at which the hypothyroid function sets in is important, for, if this takes place *after* puberty, when the sexual glands are active, a somewhat different reaction of the pituitary takes place."

It has long seemed to us that psoriasis is a disease of indirect origin, approaching eczema in its wide range of etiology, although not allergic, and it might be regarded as the result of endocrine change in certain individuals—pituitary by preference—such endocrine change being brought about by primary abnormalities of diet, by septic absorption or by any change that would alter glandular function.

If the endocrine system has complete control of the body, why could not such a baffling disease as psoriasis be under the control of that system, with particular reference to those glands whose altered function affects the dermal and mesodermal structure—the thyroid, pituitary and probably the parathyroid?

CONCLUSIONS

1. Some form of dietary regime, either low nitrogenous or carbohydrate diet, may be of value in certain cases of psoriasis.
2. There should not be a routine, fixed diet for all cases.
3. Diet may be used as an adjuvant method of treatment.
4. Dietary regime should be instituted in acute cases or in cases of markedly abnormal diets.
5. In severe or refractory cases requiring hospitalization Schamberg's dietary treatment would be especially applicable.
6. Random dietary measures at the patient's discretion are generally useless.
7. In ambulatory cases a strict dietary regime (Schamberg's) has not been found to be practical.

1309 DAVID WHITNEY BLDG.

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SIX CENTURIES OF MEDICAL PROGRESS IN SWEDEN*

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Medical historians in Sweden are fortunate in having authentic records dating as far back as the year 1302. The culture of continental Europe reached the Scandinavian peninsula rather late for Christianity was not introduced in Sweden until 829. In that year King Bjorn called the French Benedictine Father, Ansgar, to come to Sweden and preach the gospel to the heathens. It is known that the Vikings—the Nordic pirates of the sea—were in their glory between the eighth and eleventh century, still under influence of Pagan Gods.

THE PERIOD FROM 1302-1680

The town of Uppsala had become a center of religious activity and with Christianity came charity and benevolence. Here we find the first record of an organization for the care of the poor and sick. In 1302 the priest, Andreas And, founded the Uppsala Helgeandshus or Domus Sancti Spiritus. From the printed records of the regulations and the incentive in founding this house we read the following: "A few charitable men, whose devotion shall never be forgotten, saw and heard that many poor, especially in the winter, suffered the most extreme misery, so that they often died from exposure; and that sick and dying were compelled to lie about on public squares and streets, were activated by the Holy Spirit to donate their money and property, gained by the grace of God, for the building of shelter for the poor, the needy and sick, which should truthfully become the House of God."

Into this house were admitted the sick of the usual kind; when there was room no one seeking shelter was turned away. The care of these individuals was entrusted to a group of brethren known as *fraternitas* who administered what little they knew of medicine, for no physicians were available. This type of charitable institution existed in many places during the middle ages. Another type of institution was known as *hospital,* and cared especially for victims of leprosy, then a very common disease.

In Sweden, as in continental Europe, surgery began as a semi-professional occupation, not directly connected with medicine. The so-called barber-surgeons were early organized into guilds, but there are no records of medical organizations at that time. The first mentioned member of the guild was that of a man named Lamprecht who came to a sudden finish. The chronicles of Olaus Petri, a reformed priest, tell how Lamprecht, while peacefully occupied in his barber shop was abruptly led to the public square and decapitated. This was the fate of many prominent men of Stockholm who for political expedience were done away with by order of King Christian II of Denmark.

There is an account of three officials in Stockholm, who in the year 1560 carried the title "Barber-Surgeons." During the reign of Gustavus I (1520-1560) there were in the army one surgeon for each company and in the navy one for each capital ship; these navy surgeons were usually hired from Germany for the duration of an expedition.

In 1571 Johan III published a privilege letter for the guild of barber-surgeons stating in the preface that these regulations were based on suggestions by the guild and approved by it; that the King had read them and found them tolerable, useful and necessary. Here are a few extracts:

1. "There must not be more than six citizens in Stockholm who have the official title of Master Barber-Surgeon. Exception is to be made only by special royal favor."
2. "There shall be an alderman in the guild, to be chosen annually by the Burgomaster and city council of Stockholm."
3. "Whoever aspires to become master barber-surgeon must present evidence of having studied abroad, and where and in what manner he spent his years of apprenticeship."
4. "No one will be admitted to the guild, unknown to the Burgomaster and city council, in order that each can be properly ex-

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amined to determine whether or not he is able to render proper services."

5. "No barber-surgeon shall bandage someone already treated. Whoever does so will be fined one pound of wax for each offense."

7. "The barber-surgeon who sets his colleague's servant against him will for each offense be fined one-half pound of wax. Should he use insulting words against his colleague the fine will be five pounds of wax."

11. "Whenever someone comes to the barber-surgeon to be treated for a sore or wound but does not care to return he shall pay one-half mark for the dressing, then go to any barber-surgeon he chooses."

14. "All members of the guild shall, each Sunday, put a small coin in the collection box for the fund to help a brother who may become poor through fire or otherwise."

15. "When a brother, his wife or child die, the members of the guild and their wives shall accompany the dead to the grave. Whoever neglects this shall be fined four marks for each offense. This money is to be collected for the fund to assist members in distress."

23. "No brother or apprentice shall associate with a quack, neither receive plaster nor salve from such. Whoever does so shall be fined forty marks and himself be known as a quack."

In 1663 the *collegium medicorum* was founded in Stockholm and received its privileges by royal decree. This constitutes the foundation upon which medicine in Sweden came under direct control of the state. The college had authority over the many guilds of apothecaries, chemists, oculists, stone and hernia cutters, bathers, barber-surgeons, etc. One paragraph stated that no surgeon or pharmacist shall include medical practice unless he has passed a public examination in the presence of a physician who is a member of the medical college. The rules were definite and fines were imposed for disobedience; when a serious case came under a barber-surgeon's care, he was to consult a member of the medical college. People were allowed to sell drugs at the markets only after approved by the medical college. As soon as the market was over these merchants were to leave the town promptly; they were not allowed to visit the sick or send them medicines.

Many of the prominent barber-surgeons of this period were Germans with whom the Swedish military men had made contact during the continental wars.

THE PERIOD FROM 1680-1797

In 1680 the guilds of barber-surgeons came under a director-general named Salinus, who had learned the trade from his father, then added to his knowledge by extensive journeys in Germany, France and Wales. He instituted new rules designed to improve the training of the barber-surgeons who by this time were known as members of a profession rather than a trade. A hall for the study of anatomy was provided by the city of Stockholm and executed criminals were used for dissection. No more than eighteen master barber-surgeons were allowed in Stockholm, in order to prevent a ruinous competition and to keep the art from degenerating and losing its dignity. A sufficient number of apprentices were to be trained by the masters so that the army and navy could be adequately cared for. The by-laws provided that the master barber-surgeons were to be called together at certain times during the year, to confer with each other and report observations and experiences to improve the profession and give it a good name both at home and abroad, thereby honoring the King, the country and themselves.

Things did not always go smoothly. A royal letter in 1682 states how the King, having learned with chagrin that the recently graduated master barber-surgeons were unruly, refused to be guided by their elders, caused trouble and dissention in the guild and set poor examples for the apprentices, so that their bad behavior threatened the good reputation of surgery, threatened that if gentle rebuke, good advice and moderate firmness did not improve conditions, punishment and fines would be instituted. The president of the college was rebuked in a letter of 1685 where his attention was called to the fact that the quality of surgeons provided for the army and navy was not up to standard. He was ordered to stiffen the examinations for the men who were to serve the thousands of officers and men who risk their lives and blood for the fatherland.

The guild had always been tax exempt and when the city of Stockholm wanted to subject the members to taxation a protest

was submitted to the King. It stated that since the barber-surgeon's work was not commercial but humanitarian and the guild had to provide medical service for the army and navy, and furnish services early and late to those who requested it, it was enough that they had to pay their servants. An exemption was granted as long as barber-surgeons were not engaged in commercial work, but cancelled by King Charles XII in 1700 on the ground that whoever is entitled to protection must also pay tribute.

Upon recommendation of the director-general of the guild, King Charles XI, in 1686, published articles which were to become its magna charta and give it the necessary strength to live through years of difficulties.

His Royal Majesty graciously offered the following rules and regulations for the guidance of barber-surgeons of Stockholm, and those coming under its jurisdiction. "All members should humbly submit and attentively be guided by these." "Whoever chooses to become master surgeon in Stockholm, or elsewhere in the country, must prove, that he is of legal birth, has learned the profession well, served at least four years as an apprentice and is well posted in the art. He should then serve three years with a master who decides as to his capabilities."

Examinations were to be conducted before the entire guild, some city magistrates and the personal physician to the King. The candidate was required to demonstrate manual operations and manipulations belonging to surgery. If found capable he was asked to demonstrate his skill in the preparations of salves, plasters, ointments and to present other proofs pertaining to external remedies. When graduated he was required, as of old, to give twenty-five dollars in silver to the professional fund before he was permitted to hang out his shingle and practice his art unmolested.

Frequently disputes occurred concerning the right of barber-surgeons to practice internal medicine. This required additional rules, sponsored by the medical college which specifically prohibited the use of internal medicines by barber-surgeons, and directed them to stick to their manual operations, plasters, vesicans, gargles, etc. This annoyed the barber-surgeons a great deal and the director-general complained to the King that the barber-surgeons had practically lost their legal rights; that the army and navy surgeons would be unable to treat patients as previously directed. The King then ordered four master barber-surgeons to appear before the medical college to discuss the interpretation of the new rules. The president of the college explained that the barber-surgeons had their initial training in a barber-shop and that it was entirely manual; why should they wish to practice an art they knew nothing about? To this the surgical director replied that no one was a surgeon unless he knew how to give medicines. He could never learn this except through practice and if this was forbidden he would be useless in the military service.

These difficulties were adjusted and the surgeons gained their point for the time being. There were only a limited number of physicians while the surgeons were numerous. The army and navy were entirely in their hands and for some time the surgeons continued to treat internal diseases as formerly.

During this period there were many surgeons who felt that there should be no estrangement between physicians and surgeons, that after all they represented one profession and one purpose. To many physicians it seemed intolerable to be on the same level with a surgeon who had learned his art after the fashion of a trade. The abuse of the title, *"Doctor,"* seemed to irritate the physicians a great deal. This led a brilliant member of the medical college, Urban Hjarne, to publish an article in 1700, which explained the meaning of the title *"Doctor."* He maintained that it seemed unreasonable to use the dignified title *"Doctor"* for an oculist, hernia or stone cutter, to say *Doctor Occulorum, Herniæ, Lithotomæ,* or for a corn cutter, *Doctor Clavorum,* or for one who cuts fistula in ano *Doctor Fistulorem.* This would be as ridiculous as to call an organist the Pastor, or a chaplain a Bishop, or a common city servant a Councilman, or a court clerk a Judge. He concluded that all those who performed limited services in medicine should come under the authority of a doctor of medicine.

To illustrate the strained feeling between physician and barber-surgeon, the following story should prove interesting. A certain oculist by the name von Oltken had received a passport for foreign travel and unnoticed

by the authorities added the word "Doctor" in front of his title *"Operator* and *Oculist,"* thus reading, *"Doctor, Operator* and *Oculist."* This trick caused a violent altercation between himself and the city physician, Dr. Lars Micrander, and led to a legal process, the description of which has considerable historical interest.

On the second day after Easter in the year 1700, Dr. Micrander happened to pass the above mentioned von Oltken who was engaged in conversation with a member of the city council. Upon hearing this man call von Oltken *"Doctor,"* Micrander exclaimed, "for what reason do you call him *"Doctor"* who is no doctor but an oculist and operator, engaged as such by the government and deserving no other title?" To this von Oltken replied: "Before I knew or saw you I was a doctor in my profession." Micrander then said: "I have become an old man who has known you for many years when you still were an apprentice by Master Mickel Heyn." The storm broke loose when von Oltken exclaimed, "I regard you a cheater until you prove I was ever an apprentice by Mickel Heyn." A violent argument ensued during which von Oltken overwhelmed Dr. Micrander with insults. In order to prevent a gathering of people they crossed the street to a doorway where von Oltken attacked his accuser and even struck him over the head with his cane and injured his finger. Micrander left, explaining that he would have nothing further to do with von Oltken and that it would be beneath his dignity to fight with one who came under his supervision. In the court proceedings which lasted two years, Micrander, who had a great sense of humor, sued von Oltken on the following grounds:

"1st—According to the latest ordinance against those who with words or deeds abuse their superiors, four double fines for bodily injury, three double for abusive language, and prison for anyone who sets himself up against a superior.

"2nd—As an offender against the observance of Sundays and holidays. (Easter is observed for three days in Sweden.)

"3rd—Public disturber of peace, especially since the Royal Guard was approaching.

"4th—Because Her Royal Majesty was in town at the time, in Her castle.

"5th—Because he had broken his oath of loyalty to Her Majesty the Queen."

Von Oltken in defending his doctor title referred to his passport given by the Queen where out of gracious consideration for his art the title *"Doctor, Operator* and *Oculist"* was given. He declared himself "as good a man in his profession as the doctor was in his, and that he had shown proofs which the doctor could neither understand nor was able to repeat." To this Doctor Micrander replied, "If such absurd position should prevail there should be no difference between a peasant and a noble, and any cobbler in a town would be as good as the best, since the latter did not understand the mending of shoes. It was very noticeable that von Oltken talked only as far as his senses permitted and that he considered with all right thinking people, that it was much below the dignity of a doctor to incise cataracts, since many circumcisers and quacks ran about the country doing such work."

Quacks, humbugs and advertising specialists from far and wide had a fertile field during this period. The public squares were the scene of making the blind see and lame walk, loose teeth were fastened and black teeth were made white as snow. Often the mayors of towns were invited to see the itinerant oculist incise cataracts. The immediate return of vision was dramatic, and served to get these people lengthy testimonials with the affixed seal of important public men.

During this period a real advance was made in ophthalmology, which until recently had been in the hands of traveling oculists and cataract cutters. Many valuable contributions on the subject have been preserved from this time. One Carl Frederik Ribe was particularly distinguished. He had studied in the most important centers in Europe and was a friend and fellow student of John Hunter. He became a member of the Royal Academy of Science as well as its president and later published "Surgical Attempts and Notes on Diseases of the Eye." He is considered the father of Ophthalmology in Sweden.

The most distinguished of the surgeons of this period was Olof Acrel, the son of a minister, who was born in 1717. He was a student at the University of Uppsala and decided at the age of sixteen to study medicine. He became a surgical apprentice with a celebrated Stockholm surgeon and finally assistant to the old city surgeon, Solomon Schutzer, who allowed the young man to take charge of his surgical and administrative work. In 1740, at the age of twenty-three, he left for foreign lands where he continued his studies with energy and enthusiasm. He visited the famous German

Universities at Wittenberg, Halle, Leipzig and Jena; and remained for a long time at Gottingen, studying anatomy and physiology under the famous Swiss Scientist Albrecht von Haller, surgery under Richter and obstetrics under Roederer. He went to Strassburg to study anatomy under Professor Eisenmann and prosector Hommell. At the public hospital he observed operations, took part in bandaging and attended lectures on medical subjects. In 1742, in company with a Danish physician, he undertook a long journey on foot, wandering to Basel and Bern where he attended the famous Insel Hospital and there learned surgical technic. The journey continued to Freiburg, Lousanne, Geneva, Milan and Tourin where his attention was called particularly to hospitals and institutions for care of the sick. He continued to Grenoble, Lyon and Besancon, spending some weeks at each place. He made friends with the best known physicians and surgeons and was allowed to perform numerous operations in the public hospitals. Over Colmar he returned to Strassburg where he became assistant prosector. He continued to Paris, visiting the famous clinics. In the summer of 1743 he visited Le Cat in Rouen, took a trip to London to see Cheselden and Sharpe, also numerous hospitals. At this time he hurried to the French Army Camp where he was at once accepted by the surgeon-general of the army, Gerhard, as his assistant at the field hospital at Worms. Later he was ordered to the fort of Lauterburg and soon became chief surgeon in the twelve hundred bed military hospital. By order of the military authorities he lectured and gave surgical instruction to his twenty-four assistants. The fort was captured by the Austrians in July, 1744, and Acrel became a captive; he was soon liberated on his word of honor not to join any military service for one year. Although offered the position of prosector at Strassburg he preferred to return to Sweden. Shortly after returning home, Acrel became a member of the Surgical Society and quickly gained an excellent reputation and large practice.

The results of Acrel's unusual training and experience were published in 1745 in a monograph entitled. "An Explanation of the Character of Fresh Wounds, concerning their Special Nature, Signs and Progress, with an Annex about a few Conclusions Regarding their Lethality and How the Evidences for it May be Demonstrated." This was Acrel's debut as a scientific writer and brought him great renown from contemporaries everywhere. It was translated into the Dutch and German languages and Haller proclaimed it the most perfect on the subject. He became a member of the Royal Academy of Science in 1746 and of the Surgical Academy in Paris in 1750.

We give this extensive biography of Acrel because it was due to him that a scientific school of medicine was developed in Sweden. During the following fifty years his influence was reflected throughout the entire country by the building of hospitals and teaching clinics. He is deservedly known as "The Father of Surgery in Sweden."

In 1752 the Serafimer Hospital in Stockholm was opened with Acrel as chief surgeon. A new era began for medical teaching in general and of brilliant achievements in surgery in particular. This was in a large measure due to the services of Acrel as teacher and writer. The medical department was in charge of a distinguished physician, Johans Lorens Odhelius.

It is of considerable interest to note that the first man to receive the degree of Doctor of Medicine at the University of Uppsala was a man who had been trained in the school of surgery. He was Peter Hamnerin, who graduated in 1738 and was the first to urge the union of medical and surgical studies. This occurred in 1741 through an appeal to the King in which he expressed his conviction "that a doctor of medicine, besides being a good pharmacist, must of necessity be a good surgeon in order to be given the confidence and responsibility due a provincial physician." In order to gain this end he suggested that the teachers on the medical faculty were to learn enough about surgery to enable them to instruct their students in both theory and practice of medicine and surgery. A medical student was expected to gain experience in the practical art of surgery by remaining for some time with a surgeon.

It took years before the learned faculty of Uppsala finally replied to Dr. Hamnerin's proposition; the reply was written in the most cautious language, actually sidestepping the issue. Hamnerin answered by pointing out the following: "As much as it should please me if the sciences were so

taught and managed that the suffering could from one person receive the attention, care, advice and help, which he now must seek from two and at double cost, as much does it annoy me to doubt that such purpose will ever be gained while the higher authorities do not permit the combined teaching of the two sciences. The question does not concern me personally but all, and for my part I can do nothing further; I am satisfied to have announced the necessity of this and thus saved my conscience."

Half a century elapsed before the foundation was laid for the wedding of medicine and surgery. This occurred in 1797 following the dissolution of the Surgical Society.

The period between the opening of the Serafimer Hospital in Stockholm in 1752 and the dissolution of the Surgical Society in 1797 is full of interesting episodes. Both the conservatives and the progressives challenged the orderly development of medicine with their extreme views, secret propaganda and intolerance.

In 1757 a memorandum regarding the requirements for a graduate surgical apprentice read as follows:

1. In anatomy, he should know its divisions, especially know all bones in the human body by their names, positions, joints and usefulness.

2. Surgery, what it is, its divisions, the most common terms of the art. Explain the best locations for venesection and what parts could be injured thereby. State indications for venesection and quantities of blood to be drawn. He should know the following: external inflammations by names, their causes, differences, signs, progress and treatment; the characteristics of fresh wounds and their causes; how to stop bleeding, dress wounds and apply bandages; the nature of chronic sores, draining pus and the most useful remedies; fractures and displacements in general and how they should be treated.

3. In materia medica and pharmacy he should know certain substances and be able to differentiate and name which are balsams, emollients, resolvents, etc., their composition, dosage and effect. After this there were enumerated about ninety chemicals and fifty mixtures; finally the most useful pharmaceuticals and medical weights up to one pound. This qualified the young man to assist a master surgeon. The next examination was taken after serving some years as an assistant.

The first professor in anatomy and surgery was Roland Martin, a physician graduated from Uppsala in 1751 who later studied anatomy and surgery in Paris. His lectures laid the foundation for the scientific study of anatomy. Professor Martin became a member of the Royal Society and received its gold medal for a medical thesis, "Evidence that the Loss of One or More of Man's Special Senses can be Compensated by a Greater Perfection of Another." Although not a research man of great originality, Martin gave evidence, in his numerous writings, of critical and thorough knowledge of the material at hand.

In a learned paper of 1756 is an announcement that a certain professor in Botany, named Tuven, had been engaged by the Surgical Society to lecture on medical plants; also that he would take the students on botanical excursions.

It was necessary for all surgeons, but more especially for those practicing in the country, to be able to gather plants for common medicinal uses. The announcement was an eloquent appeal to students to avail themselves of this useful and beautiful science.

A varied program of lectures and demonstrations were held in Stockholm during these years by learned members of the surgical society. In 1756 it was proposed that the society should publish semi-annually, "Observations on Surgical Cases of Unusual Interest, which occur in Practice, to aid Scientific Progress, Benefit the Public, Encourage Surgery and Honor our Society." Progress was slow and it took thirteen years to accomplish this.

Many controversies occurred concerning the method of training physicians and surgeons. Should these continue as separate professions or unite into one? The definition as to what constitutes a surgeon or a medical man and what his qualifications should be were discussed verbally in public lectures and in communications to the authorities; some were signed by leading men, others were anonymous.

A proposition had been submitted to the parliament in 1756 that the medical college should be given final authority in cases of medico-legal interest. Since both medical and surgical cases would be argued in the courts it provoked heated opposition by the surgeons, on the ground that medical men

would be allowed to define and dictate the limits of surgery. A new proposition was then made that the medical college should add to its directing board four surgeons and four pharmacists. This caused a sensation in medical circles as evidenced by a private letter from the brilliant physician Linneus: "Oh good God, if surgeons and pharmacists will be admitted to the medical college what will happen next?" The Surgical Society later opposed this plan of a mixed college because four members would constitute a minority, unable to assert themselves, and thus great harm to surgery and to the entire country would result.

Not only the parliament but the public at large became involved in this controversy between medicine and surgery. Printed leaflets discussed the subject pro and con. The medical men looked down upon the surgeons as hair cutters, barbers, bone setters and plasterers who lacked training in the arts and philosophy which are required of medical men. The surgeons emphasized the practical value of their training and ridiculed the over-emphasis of the academic training for doctors of medicine, also that their Latin and knowledge of languages was nothing unusual.

A sane solution was proposed by Herman Schutzer in 1761:

1. "The royal sanitary commission shall have a supreme authority over the medical department, as soon as three representatives of each society are elected to membership.
2. "Medical teaching shall be centralized in the country's capital.
3. "Physicians and surgeons shall enjoy equal respect and encouragement as well as liberty in the practice of their profession.
4. "The army and the country shall be amply supplied with skillful surgeons.
5. "The medical state funds shall be available equally to the medical college and the Surgical Society."

As time went on there was a marked improvement in the standards of surgical training. The government appropriated annual scholarships for post-graduate studies abroad for surgical students who were carefully chosen by the proper authorities. The candidates were required to pass a rigid examination in order to secure this financial aid. They had to follow certain itineraries, correspond with the society and report their work in anatomy, surgery and obstetrics.

It should be observed that the controversy between physicians and surgeons in Sweden at this time was not limited to that country alone. The same dissention occurred in all of continental Europe in proportion as surgery approached the level of a science and required a more comprehensive fundamental knowledge.

From the very beginning of the establishment of the first modern hospital in Stockholm in 1752, Acrel stated that the purpose of the Serafimer Hospital was not only to care for the sick but to teach and develop physicians and surgeons and to provide opportunities to gain fundamental knowledge which they could later increase by foreign travel and studies. They could observe the sick and get bedside experience and in cases of exitus have the opportunities of necropsies, which elsewhere in Sweden was considered abhorrent at that time. The most important results of the scientific work at the Serafimer Hospital was published by Acrel in 1759. This publication was entilted "Surgical Histories, Observed at the Royal Hospital, Collected and Printed with Additional Notes from Daily Records." This was Acrel's most important work and through it he became recognized as one of the great surgeons of that period. This work remains, up to the present, one of the most important contributions to medical science that ever emanated from Sweden. Many of Acrel's students contributed case histories and descriptions of operations. This collection, which was translated into Dutch and German, was, in the opinion of a contemporary, "a record of wise and real experience which can never become old; it remains an inheritance, which time cannot destroy nor a spendthrift dissipate."

Considerable has been said about surgeons and comparatively little about physicians, but at this time two medical men should be introduced whose influence in the world of science has carried their names down through the ages. Reference has already been made to Linneus and the extraordinary high regard in which he is held prompts a short account of his life. Karl von Linne, usually spoken of as Linneus, was born in 1707, the son of a minister. His parents planned a theological career but he insisted on studying medicine and botany, the usual combination of studies. He first attended the University of Lund but later moved to Uppsala where, in a short time, he became recognized as a scientific investigator of botany and a writer on that subject which made him famous. There was no medical

degree bestowed by the University of Uppsala at this time; to obtain this a foreign journey was necessary. Accordingly Linneus set out for Holland in the year 1735 and in June of the same year gained his M.D. degree from the University of Harderwijk. His thesis, written in Latin, was entitled "New Hypothesis Concerning the Cause of Intermittent Fever." He remained three and one-half years in Holland working night and day in the field of botany, publishing many books which completely revolutionized the understanding of that subject. He was patronized by the greatest intellects and scholars, made journeys to London and Paris and became known as the "Prince of Botany." Many flattering offers tempted him to remain abroad but homesickness forced him to return to his native land in 1738.

Linneus settled down in Stockholm where, in a short time he gained a large practice and became associated with the leading men in arts and sciences. He was described as particularly keen in understanding the etiology of disease and in this respect emphasized that here, as elsewhere, nothing could compare with observation. He became physician for the Admiralty and helped organize the Royal Society of Science in Stockholm, becoming its first president. In 1740 Linneus was called to the University of Uppsala to become professor in "The Practice of Medicine." He soon exchanged that post, preferring to teach natural science, materia medica, dietetics and diagnosis (Semiotic). No Swedish scientist has received greater recognition during his life or been more honored after death than Linneus. He remains to this day one of the world's most celebrated investigators in the field of natural science. He died at the age of seventy-one, and the King, in announcing his death to the parliament, declared it a national calamity. Linneus' brilliant personality, scientific contributions and general influence were so extraordinary that it becomes difficult to avoid making this a biography instead of a description of a period.

The other celebrated physician appeared a little later in the eighteenth century. He was Berzelius, who was born in 1779, and studied medicine at Uppsala with great enthusiasm. He received his medical degree at Stockholm in 1804 where he continued to live and carry on his work up to his death in 1848. Berzelius became professor of medicine and pharmacy and in 1807 assisted in the formation of the Swedish Medical Society. He visited England, France and Germany and personally knew Argo, Ampere, Humphrey Davy, Wollaston and Humboldt. He knew Goethe and during the meeting of Natural Scientists in Berlin in 1828 was given the place of honor. Berzelius was a member of the Scientific Societies of the World and published hundreds of treatises on chemistry, in Swedish and foreign journals. In a classic work on the history of chemistry H. Kopp states: "In order to review completely Berzelius' work one must of necessity consider the entire field of chemistry. There is in that science no subject to the understanding of which he did not contribute; there are no basic elements, concerning the combination of which more knowledge was not gained through him. Galvanism, electrochemistry, the atomic weights, molecular theories, the nomenclature and formula of basic elements all come within the realm of Berzelius' work. It was to him that our William Beaumont turned for assistance in the analysis of gastric juice, during his epoch making experiments. At his death, Berzelius was mourned by the entire enlightened world. The Pharmaceutical Society of Leipzig, Germany, sent to the Swedish Academy of Science, a giant wreath of oak leaves made of silver with the inscription: "To the memory of the Master of Science, J. J. Berzelius."

In 1781 appeared the first Swedish medical journal known as *"Weekly Journal for Physicians and Students of Natural Science."* The editor was a surgeon, Hagstrom, who had studied natural science at the University of Uppsala. He received the degree of Doctor of Medicine from Abo University of Finland in 1781. Hagstrom was a former student of Acrel and had been profoundly influenced by that remarkable man. He became prosector in anatomy and professor and director of the Surgical Society in 1795.

We find that trained physicians gradually became interested in the practice of surgery. Of these, Hagstrom was an outstanding example. An incident which profoundly raised the standing of surgery was the promotion of Olof Acrel to Doctor of Medicine by the University of Uppsala in 1760. Doc-

tor Linneus had always shown a decided prejudice against practitioners of surgery. He often expressed his opinion on the subject and I cannot refrain from quoting a letter and report from him that touches this particular matter. "In accordance with my dear colleague's advice I have adhered strictly to the necessity of Professor Acrel's journey hither, in case he should be offered a medical degree. When dean Rosen arrived he observed that it was the wish of the entire medical college that he be offered the doctorate, for which the professor was anxious; my colleague insisted that a letter concerning this be sent to the chancellor. This explained both the Professor's willingness and dislike of coming here. I have still adhered firmly to my resolution until I could learn my dear colleague's opinion. I know that Professor Acrel stands well with the most illustrious; I have heard that dean Rosen has already interceded for him with his excellency, who has agreed; I believe it will happen whether I agree or not. Let me have my dear colleague's thoughts on the matter by next mail." Dated 5 May 1760.

Linneus' report to the faculty, 20 May, contains the following regarding Acrel's promotion. "Since Herr Professor Acrel has distingushed himself so markedly from all other surgeons through solid enlightenment in all parts of medicine and an extensive medical practice in the capital but most prominently through his distinguished book about Cures in the Hospital, which is a jewel full of so many glorious observations etc. the faculty found it reasonable to distinguish him from the less educated by offering him a medical doctorate. They feared, however, that such distinction would give cause for abuse and for that reason he was summoned by the faculty to appear in this place and by a discussion show his knowledge. Accordingly he was heard by us in the various subjects, especially in those parts which essentially concern medicines, in all of which he proved himself so well informed that the faculty did not have many members of such experience and knowledge. The faculty found that he should be recommended to the most illustrous by eulogies and a true report, that he had proved his insight in all details, which anybody had up to the present been able to demonstrate and that he was thoroughly approved by the faculty."

It is stated that Acrel was not anxious to receive the honor proferred him without being duly examined. He left Stockholm at three o'clock in the morning, reported at Uppsala at eight and after completing his mission returned home by seven in the evening to attend to his patients. The round trip between those cities represents eighty English miles, a considerable voyage for those days and evidently a sacrifice of time for the busy physician.

We have learned from the above that the bitter antagonism between two main branches of one profession was gradually solved. By an important decree of 1797 the Surgical Society, as representing a profession, ceased to exist. The superior training and intellect of a few outstanding individuals of both branches climaxed the union.

The further development of medicine in Sweden during the last century, followed the same channels as observed in all other civilized countries.

THE PERIOD FROM 1797-1933

In conclusion I would like to mention only a few of the outstanding Swedish contributors to medical science during the last century. Among these, few can compare with Anders A. Retzius who was born in Lund in 1796. He became professor in anatomy at the medical college of Stockholm in 1824 and in coöperation with the brilliant Berzelius was active in putting medical teaching on a firm scientific basis. He was a renowned anatomist and founded the systematic teaching of pathologic anatomy as well as a rich anatomic museum. In comparative as well as human anatomy he remains to this day one of the world's greatest contributors.

From Acrel up to the middle of the nineteenth century most of the practical surgery was carried on by the chief surgeons at Serafimer Hospital in Stockholm. The best known of these were Schulzenheim, Bjerken and Ekstromer. On the medical faculties of Uppsala and Lund the position of surgery was not strong. The reason was that surgery was usually combined with anatomy or some other branch; for instance one professor represented anatomy and surgery so that actually the professors were hardly surgeons. The first truly representative surgeons at these Universities came with Mesterton, at Uppsala in 1857 and Ask at Lund in 1859. At Stockholm, Santesson and Ros-

sander had already been active for some years. These four men practically controlled Swedish surgery for about thirty years. They were all excellent men who had traveled and studied extensively and worked under men like Velpeau and Nelaton in Paris, Schuh at Vienna, Langenbeck in Berlin and at Montpellier. Although none of these men left any unusual literary contributions it should be acknowledged that Santesson's "Critical Review of the Theories of Inflammation" would probably have gained fame had it reached the world through the medium of a better known language than Swedish.

It was not until the next generation that modern surgery became established and that the epoch making discoveries of Pasteur and Lister were applied in practical surgery. The names of John Berg and Karl Gustaf Lennander are most intimately connected with this era and they remain, up to the present, the most outstanding men in surgery since the days of Acrel. John Berg became professor of surgery in Stockholm in 1885. He was an outstanding worker and teacher and contributed a great deal to the literature of modern surgery in nearly all its branches. Berg was a great organizer and clinical teacher and it was through his efforts that a modern hospital was built in Stockholm which became the first large institute for the training of nurses. This hospital is known as Sofiahemmet, named after the late Queen Sofia, consort of the great monarch Oscar II.

Lennander became professor of surgery at Uppsala in 1891. He was probably the best known of modern Swedish surgeons. He died at the early age of fifty-one but had already made many contributions of great importance. He is probably best known through his writings on abdominal surgery, especially appendicitis and peritonitis. His most mportant work is his careful study on the question of sensibility of organs and tissues, especially in the abdominal cavity. This became of great practical importance in the use of local anesthesia and with regard to the question of the mechanism of pain in disturbances of internal organs. He is quoted frequently in modern textbooks. In Lund, modern surgery became of importance first with the appearance of Jacque Porelius in 1898. His successor in the chair of surgery is Professor Gustaf Petren, an excellent surgeon, teacher and writer on surgical topics.

In roentgenology and radium therapy Gösta Forssell has become internationally known. He is at present professor in medical radiology at Stockholm. His contributions are numerous, some are epoch making, for instance "Observations on the Movements of the Mucous Membrane in the Digestive Canal." He is the founder of Radiumhemmet in Stockholm—an extraordinary organization for cancer research and treatment, subsidized by the government. It enables the most humble to receive expert treatment at very low cost as well as centralization of scientific records. Forssell is a great traveler and linguist. He has lectured in many countries including U. S. A. where he was invited to give the Caldwell lecture, and has had many honors bestowed on him.

Allvar Gullstrand, professor of ophthalmology at Uppsala is famous for his contributions to ophthalmology, physiologic optics, astigmatism, and others too numerous to mention. He received the Nobel Prize in Medicine in 1911 and at that time delivered a lecture "How I found the Intracapsular Mechanism of Accommodation."

Hans Jacobeus is professor in Medicine at Stockholm, and is best known for his work on Intrapleural pneumolysis in connection with collapse-therapy.

Olof Hammarsten was, up to recently, professor at Uppsala. He has been a great research worker in his field and a prolific writer. He is the editor of a well known handbook on Physiologic Chemistry.

S. Henschen, up to recently professor in internal medicine at Stockholm, is well known for his contributions to studies on diseases of the brain and nervous system. He wrote a very complete system in German on "Clinical and Anatomical Contributions on the Pathology of the Brain" in four volumes.

This sketch would be incomplete without including Axel Key among those who have made Swedish medicine known to the outside world. Axel Key was an anatomist of great renown, a celebrated hygienist, academic teacher and medical historian. The hundredth anniversary of his birth was celebrated in Sweden during the last year. Key became the dean of the medical college in Stockholm and was during his entire life a veritable giant in medical and cultural activ-

ities. Besides his innumerable scientific writings be also carried on a great deal of historical research. It was his custom, while dean of the medical college, whenever a new professor was installed, to issue a formal invitation by means of a program consisting of a treatise on some historical aspect of Swedish medicine. To Key must be given the credit for communicating to the world the medical writings of the Scandinavian countries. He was convinced that there was a wealth of valuable material, and spent the best part of his life and modest income to establish and maintain a medium for literary expression. This work was begun in 1863 with the publication of Northern Medical Archives. Key was so convinced of the value of Scandinavian medical contributions that he entertained hopes that this could be done in his native language and thus become world literature. For obvious reasons this could hardly succeed. It was he, who by his untiring work laid the foundation for the journal known as Acta Scandinavica, published in the modern languages and representing every field of medical science.

Einar Key, son of the latter, is at present professor of surgery in Stockholm and editor of Acta Chirurgica Scandinavica. He has contributed a great deal to the surgical literature of the world especially on the kidneys, lungs and blood vessels. I am indebted to him for the material which forms the background for this essay.

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RECENT CONCEPTIONS OF OBESITY

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The study of this disease has been much neglected by medical schools both in this country and abroad, notably England and Canada. This neglect also applies to the study of dietetics, nutrition and diet therapy. These views have been admitted and endorsed by many leaders and teachers in the medical profession, most recently by Dr. R. M. Wilder, Professor of Medicine, University of Chicago, in his Chairman's Address at the last meeting of the A. M. A. at Philadelphia, in June, 1931. Dr. Wilder went on to say that many of the newer phases along these lines have not yet been incorporated into the crowded medical school curriculum; so that the education of the physician in nutritional diseases is not much better than that of a layman. Education of physicians comes mainly from circulars of commercial houses and propaganda of purveyors of food. This propaganda is often unscrupulous and arouses such critical reesntment from physicians that they become unreceptive to authoritative information. So the profession is acquiring an antipathy, even hostility, to diet therapy, and thus arises the prevailing carelessness in these matters.

It has been estimated that one-fifth of the American people are obese. If now we review the causes of obesity, we find that most authors divide obesity into three groups: (1) Exogenous type—the simple or dietetic obesity, which refers to the condition of those persons with normal metabolic rates who over-eat and under-exercise; (2) endogenous type, or that due to endocrine dysfunction, and (3) the constitutional, congenital or hereditary form, in which it is believed normal for certain people to be under or over average weight because they are simply following out laws of inheritance.

In support of the endocrine dysfunction theory, it has been pointed out that obesity is very apt to occur at puberty, during pregnancy, after menopause, and after marriage, but obesity is just as apt to occur whenever an individual changes his social status (*e.g.*, a Ford worker becoming a business man or benefiting by an inheritance) which is often accompanied by a change in nutritional status because of increase in diet or lessened expenditure of energy. Errors in pituitary, gonadal or thyroid function are frequently

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considered the cause of obesity (in about 3% of the cases studied). A patient with thyroid deficiency is supposed to become obese because of lowered basal metabolic rate, but lack of thyroid secretion as a cause of obesity is much over-rated. One sees very few persons who are grossly overweight because of lack of thyroid secretion, for example, one rarely sees a tremendously obese myxedema patient, for this disease not infrequently impairs the appetite, and if a person eats less obesity is impossible.

The most common gross obesity is attributed to pituitary disorders. Fröhlick's syndrome, defined as a general adiposity accompanied by sexual infantilism, in which adiposity is especially distributed about the breasts, hips and lower abdomen, so-called "girdle fat" of pituitary disease, is attributed to pituitary insufficiency on the basis of a tumor of or in the neighborhood of the pituitary gland. It is the anterior lobe and its hormone antuitrin that is supposed to be involved. A sugar tolerance curve on such a patient usually reveals an increased ability to utilize sugars. The fasting blood sugar is usually below the normal level or at the lowest limits of normal. One mechanism for the production of hunger is a low blood sugar and these patients have a low blood sugar chronically. Their appetite is thereby stimulated and an abnormal appetite is produced. Physicians have even recommended the use of insulin to remove sugar from the blood stream, in order to increase the appetite of the undernourished, and have claimed good results by following this type of therapy. It is not unlikely that there is a peculiar mechanism for handling sugar in patients suffering from hypopituitism.

Gonadal obesity is almost non-existent, but occurs often enough to be included in this category. Dercum's disease is a special form of gonadal obesity, in which there is pain on pressure in the region of the thighs and the pelvis. This condition is very rare. Trochanteric fat is generally associated with ovarian disease. Associated also with possible ovarian disease is a paradoxical obesity, so-called progressive lipodystrophy, in which there is a loss of subcutaneous fat in one portion of the body so that the remaining normal part of the body appears obese. This is rare, but a case was recently reported in the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY of April, 1931, by Currier and Davis of Grand Rapids, which followed a bilateral oöphorectomy.

In support of simple dietetic exogenous factors, as the only basic cause of obesity, we have the views of Dr. L. H. Newburgh and his co-workers of Ann Arbor. It was Rubner who in 1928 disproved the views of Von Noorden (Vienna) who, twenty years ago, started the belief that obese people have a low basal metabolic rate. Rubner (Germany) conclusively demonstrated that the basal metabolism is directly proportional to the area of body surface, so that the more obese the individual the higher the basal metabolic rate. Similarly Newburgh has been working for a long time to disprove that obesity is caused by endocrine disease in those patients who do not lose the expected amount of weight after they are put on reduction diets. In order to deal with this problem it was necessary for Dr. Newburgh to know in any special case (1) caloric intake of diet, (2) that the patient adhered strictly to the diet, (3) caloric output or transformation of energy for the entire period of observation of the patient. This was successfully accomplished by placing a patient in a metabolic cage so that they could control his exact intake and the number of calories estimated by laboratory analysis. In order to measure energy output or total heat production of the body, Dr. Newburgh worked out two new technics, each described in *J. Clin. Investign.,* October 20, 1931. (1) By insensible loss of weight, which enables one to determine the exact amount of body tissue destroyed and so the weight loss. But it was found that the actual body weight did not decrease, even though body tissue was being destroyed; in fact, occasionally the patient may actually gain weight, even though he is being very severely underfed. But this apparent paradox is true for any type of obesity, because it was found to occur in normal individuals, if underfed in such a way that a rapid destruction of liver glycogen is brought about. (2) By the second new technic the water exchange was recorded. It was found that there is a progressive retention of water by the body and that the weight added in this way conceals the loss of weight caused by the destruction of tissue. Such observations make it clear that the course of a subject's weight cannot be used as a measure of the metabolism, as has been done in the past.

A gain in weight may occur while body tissue is being burned up, because water is being added to the body, and the weight may diminish in the face of over-feeding, because a depletion of water is also taking place. Accordingly, the main support for the hypothesis that obesity is caused by internal disease vanishes. These studies have convinced Newburgh that there is only one basic cause of obesity, and that it is invariably the result of over-eating *i.e.*, caloric intake is greater than energy output. Why does anyone eat more than he needs? The recent studies of a dietician, Mary Harrington, in an article entitled "Appetite in Relation to Weight," appearing in *J. Am. Dietetics,* Sept., 1930, have shown the dominant position of appetite in the establishment of body weight. Especially instructive has been her observation that many obese individuals exhibit emotional unstable personalities and that they have obtained relief during periods of nervous stress by repeated nibbling of food. These persons commonly tell the physician that they are "light" eaters and do not over-eat. Analysis will show that they prefer highly concentrated food, so that the amount that will distend the stomach to the point of satisfaction contains far too much energy (calories). These people who partake of food till a certain volume has been reached, regardless of composition (whether diet contains 2 or 15 calories per gram) will gain or lose weight according to the type of food set before them. One concludes from these observations that there is no specific metabolic abnormality in obesity. All obesity is "simple obesity." The increase in weight merely represents an inflow of energy greater than the outflow, and that failure of the appetite to adjust the inflow of energy (cal.) to the bodily needs is always the immediate cause of both leanness and obesity. One might postulate, then, that obesity at first is a habit of over-eating, the over-eating being primary. Later, when the obesity is well established, the over-eating becomes secondary to the obesity. This thus constitutes a vicious circle.

Some observers believe that there is a difference in physiologic structure in those who over-eat. In this connection we have the experimental work of Raab, Smith and others, dealing with centers in the hypothalmus for fat metabolism. Clinically this view is supported by the sudden gain in weight very often following an attack of encephalitis. The actual food intake was found to be less than the basal metabolic rate. There was a disturbance in the water and salt metabolism in these patients. Dr. Rowntree, of Rochester, Minnesota, believes that we should define obesity so that it covers the exact constituent of body that is increased, for example, hyperplasmic obesity—due to increase in body protoplasm rather than fat and water, and hypoplasmic obesity—due to increase in fat and water rather than body protoplasm. Newburgh believes that obesity is not due to any metabolic error but is related to two fundamental features of humanity, (1) personality or mental type of patient. Many of the really obese are not happy-go-lucky types but are hyperemotional and suffer from insomnia, and they use food as we use cigarettes or as some people use alcohol. These people have a passion for food as a comfort and for combatting unpleasant circumstances. (2) That condition which determines his shape. We recognize relation of hypophysis to the shape of the person—Hyper- giant; Hypo- short stocky.

With these two major types, a lot of other features are associated. It might follow that the short person who becomes two or three times his normal weight bulges out in the form of large fat pads and lumps all over because he has less length to distribute his extra mass. It is interesting to observe that these lumps disappear as the result of undernutrition; not only the lumps, but the pains as well disappear. This explanation for distribution of fat is better than some special metabolic explanation. The only explanation of why some people have large appetites is that they are often acquired gradually by children through training of their parents. It is strking to see how often children of obese parents are also obese. These obese patients should be kept under observation for a long time. Gradually they lose their passion for food so that in six months to a year they are perfectly safe; their desire for food has again become normal; they now have a good habit instead of a bad one.

The patient is rather impressed when you can recite the symptoms which he is having, before he tells you, namely, dyspnea, backache, leg pain, paresthesia, gas and distress after eating, and fatiguability. These and other facts, especially the dangers of obesity, are pointed out to the patient in order to gain his confidence and coöperation, which

are so essential to success. Life insurance statistics show that from thirty to sixty years of age the lowest mortality is among those from 15 to 20 per cent below average weight. The records of the Metropolitan Life Insurance Company show that after forty years of age, 20 per cent excess weight resulted in increased mortality of 30 per cent, and if in excess of 40 per cent in weight, then the mortality increased to 80 per cent. Increased mortality of obese people is especially evident in degenerative diseases affecting the heart, blood vessels and kidneys. There is a greater susceptibility to diabetes (50 per cent), gallbladder disease, hypertension and cancer. The highest mortality rate in cancer cases was found among those obese patients who were 25 per cent or more overweight.

TREATMENT

Obese patients would consult their physicians more regularly and be less inclined to practice reducing without medical supervision if they were given more specific directions. Physicians discourage patients by giving them only certain general admonitions and a list of foods. A reduction diet requires the same attention to quantitative consideration as a diet for diabetes; the actual calories must be rigidly controlled.

Emphasis should be placed by physicians upon the prevention of obesity. The principles of dietetic reduction are understood by physicians, but the necessity of reduction is not so well appreciated. (1) The basic principle in all weight loss is caloric intake control. (2) Emphasize what foods and how much of each food is to be eaten. (3) Prescribe a well mixed diet in writing, especially lactovegetarian, with sufficient bulk and protein, minerals and vitamines; it is not necessary to emphasize vitamines if you give a mixed diet. (4) Give the patient food charts to explain accurately the different food values. (5) A basic standard diet contains about 1,000 calories divided into approximately three equal parts. This basic diet should be low in fat and calories. Fat 32 gms. Protein 64 gms. Carbohydrate 54 gms. (6) Don't reduce the carbohydrates too much in proportion to fat, otherwise you may get ketosis or acidosis. (7) Broths and soups should be diminished because they contain too much salts and it is too difficult to calculate value of solid constituents. (8) Restrict fluids, do not permit over six glasses daily—not because fluids have any influence on metabolism, but because drinking excites the appetite. (9) Restrict coffee because coffee has a characteristic of saving up albumen and of irritating the cardiovascular system and kidneys, which should not be overtaxed in obese people. (10) Diets and saline mineral waters act by stimulation of intestinal peristalsis and so assist reduction, but salts should be restricted during periods of water retention. (11) A good way to prevent and check hunger is to give plenty of cooked vegetables, if the intestine can stand much incombustible material. (12) To remove retained water in obese, the Mayo Clinic (Dr. Rowntree) uses Mersalyl (H. A. Metz Co.) a mercury compound much like Novasurol; Salyrgan and Mercurosal of Parke, Davis & Co. These obese are often anemic, so best to give them iron therapy. (13) In some patients it may be necessary to send them to an institution where exact caloric intake may be measured and adhered to. (14) Rapid weight loss is to be condemned. Not over two pounds a week for the first three weeks, then not over a pound a week, otherwise the patients lose strength and get a wrinkled, haggard appearance. Slow reduction also helps the patient to develop new food habits, and a lower body weight can then be maintained without conscious effort.

The only contra-indications to a weight reduction diet is pre- or post-operative states or when toxic drugs are being given therapeutically, *i.e.*, for increased tolerance.

Glandular therapy is only partially successful. Thyroid tablets should only be used to correct hypothyroidism, if this condition is suspected as being the cause of obesity. Thyroid has a very definite stimulating effect on metabolism and if taken in large doses causes typical thyroid toxicosis. This drug should be prescribed only by a competent physician. Much ill-health has been caused by taking thyroid self-prescribed, and occasionally death has resulted. Unless thyroid medication is accompanied by careful regulation of caloric intake, no weight loss need be expected. Laboratory tests show that no result need be expected from the use of pituitary extract or gonadal extract taken by mouth (of these drugs there is, as yet, no reliable extract available).

As far as exercise is concerned, it is only indicated in younger persons—not in middle-aged or elderly—where there already exists

too much strain on the heart muscles. Avoid over-indulgence in exercise, especially if it causes excessive fatigue and great dyspnea.

Physical measures, for example, massage, high-frequency currents, sweating cures, et cetera, are useless. There are all sorts of obesity cures and reducing fads on the market, extensively advertised even to physicians, for example, Kruschen salts—a saline laxative with supposed obesity cure properties; the purchaser is also told to diet. According to investigations of A. M. A. it actually contains 71 per cent Epsom salts, 11 per cent common salt, 6 per cent KNO_3, or saltpeter, and 9 per cent citric acid. It costs 85 cents for 4 ounces, and can do no more than four ounces of Epsom salts selling for 4 cents. The daily use, as recommended, is pernicious. The only way in which Kruschen salts can reduce weight is by the production of an artificial diarrhea that will move food through the digestive tract before all of it can be assimilated. This method of treating obesity, according to Fantus in his book "Useful Cathartics" is not nearly as rational as diminishing the food intake.

It may be mentioned that plastic surgeons are often resorted to by females for the removal of localized fat deposits, such as pendulous breasts and those in the region of the abdomen and arms (after medical methods have failed and symptoms demand relief) especially in professional dancers, actresses, etc. The operation for pendulous breasts is called "mastopexy," and often breast amputation with grafting of nipples and areola is done. Lipectomy is a plastic operation for removal of subcutaneous fat of the abdomen. According to some plastic surgeons deposits so removed do not recur, because the fat cells do not grow in scar tissue.

SUMMARY AND CONCLUSIONS

1. The study of obesity and diet therapy is very important, but has been much neglected by medical schools. The medical profession must show greater enthusiasm and more serious interest in both the prevention and care of obesity.
2. We have no positive knowledge of the control of fat metabolism by the internal secretions or special centers in the midbrain, nor can it be demonstrated that obesity is due to any metabolic error.
3. The latest conception of obesity discounts endocrine dysfunction and constitutional heredity causes, but places greatest emphasis on the exogenous factors, *i.e.*, increased appetite and over-eating as the basic cause of obesity.

HEMANGIO-MYOFIBROMA OF THE UTERUS

REPORT OF A CASE

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IONIA, MICHIGAN

The uterine fibromyomas are more common during the active sexual life of women, than in any other periods. Perhaps their development is augmented by the ovarian hormone. The relationship between the fibroid uterus and sterility is still a subject of debate on account of other causative factors, such as early menopause, and co-existing diseases of both fallopian tubes or ovaries. However from 20 to 31 per cent of married women with uterine fibroid, are sterile. Most uterine fibromyomas are subject to secondary changes. Sometimes such are malignant, degenerative (hyaline, cystic, fatty, calcareous, and atrophic) infective and circulatory.

The first true uterine cavernous hemangioma case was reported by Wright in 1895, in which the tumor appeared as a cystic intraligamentary growth. During the operation, a profuse hemorrhage was encountered. Kelly and Cullen in their series of 1,674 myoma cases have noted only three occasions of angioma areas scattered throughout the tumor. In 1926 F. C. Wright reported a case where the hemangioma was attached to the right lower segment of the uterus. He describes it as an oval mass measuring 10.5 by 5.5 by 5 centimeters, smooth, glistening, and bluish-black in color. On section he found large cavernous blood vessels filled with blood. In 1924 Singer reported an unusual case of metasta-

sis of a hemangio-endothelioma in a myofibroma of the uterus. A woman of forty-one had had seven uncomplicated pregnancies and had never aborted. In 1920 she was operated on for a tumor of the breast that had been present for sixteen years without symptoms. Histologically, the tumor appeared benign. In the last three years her menses had been more profuse and she had tearing pain in the abdomen and the sacrum. She noticed that the circumference of the abdomen gradually increased and there was a sensation of a movable tumor in the lower abdomen. Examination revealed a tumor reaching from the symphysis to almost the zyphoid process, moderately movable in a craniocaudal direction, hard but elastic on the right side, and soft-elastic almost fluctuating on the left side. Pre-operative diagnosis was made as myoma with cystic softening, and total hysterectomy was performed. The histological findings indicated myofibroma of the uterus with sarcomatous change in places, and large hemorrhagic foci. About six weeks after the operation, the patient complained of pain in the sternum. In six months, the pain in the sternum spread to the ribs, and there was an increase in the size of the abdomen. Ten months after the operation, the patient died. Autopsy showed multiple tumor nodules with hemorrhagic discolorations throughout the organs, in the bones, lungs, epicardium, pleura, parietal peritoneum, liver, kidneys, and suprarenals. The enlarged liver contained very vascular confluent nodules, which, after loss of their hemorrhagic contents, looked like cysts. Microscopically, the tumor was malignant, but neither carcinoma nor sarcoma. The enlarged liver with its large projecting bluish-red blood cysts was probably the primary site of the new growth. Because of the microscopic connection of the tumor elements with Kupfer's stellate cells, the presence of larger and smaller hemorrhages and occurrence of the newly formed vessels in the earliest stages, the tumor was classified as a hemangio-endothelioma.

Uterine hemangio-fibromyoma being a rare condition, it would therefore seem that the following case is of sufficient interest to justify its report.

CASE REPORT

No. 559. Mrs. H. S., aged fifty-seven, white, married, came to the office on March 30, 1933, complaining of high blood pressure, headache, dizziness, which had been present over seven months. During the preceding two months she had suffered slight shortness of breath, fatiguing very easily, general weakness, and pain in the lower abdomen. The family history was irrelevant, except that the father died from diabetic gangrene. Patient had the usual childhood diseases, and there is no history of typhoid fever or inflammatory rheumatism.

The physical examination revealed a well developed woman, moderately obese, height 5 feet 2 inches, weight 160 pounds. The skin was of a good texture. The hair was normally distributed. The eye sight was somewhat blurred, but the pupils of the eye were equal and reacted normally. The nose was free from abnormal discharge, polypi, or deformities. The tonsils were small and not infected. The tongue was clean, and on protrusion it remained in the midline. The teeth had all been extracted. The neck showed no abnormal pulsations or cervical adenitis on palpation. The thyroid was well outlined, soft, and not diseased. The chest was symmetrical, and respiratory movements were good, and equal. There was no dullness or flatness on percussion. The breath sounds were normal. The breasts were well developed, equal on both sides, and free from fissures, masses, and eczema. The pulse rate was 89 in both radial arteries. The systolic blood pressure was 190 and diastolic was 115. The apex beat was at the left.

Abdominal examination: On inspection there was no active peristalsis, engorged veins or operative scars seen. Abdominal wall was very obese, and somewhat pendular and bulging in flanks. On palpation the liver, kidneys, and spleen were not palpable. No rigidity or tenderness over McBurney's point. An intra-abdominal tumor, the size of a six months uterine pregnancy, was palpable, extending from the umbilicus down into the pelvis. It was quite smooth, and round in shape, and freely movable in the abdominal cavity. There was some tenderness in the left lower quadrant. On percussion elicited dullness over the lower abdomen, but no shifting dullness of fluid was noticeable. No umbilical, inguinal, or femoral hernias found. Vaginal examination revealed a second degree perineal laceration, and a marked rectocele. No vaginal, urethral, or cervical discharge. The Bartholin glands were normal. The intra-abdominal tumor was felt as being round, hard, and movable. The motion was communicated to the cervix by moving the tumor from above the symphysis. Neither the uterus, ovaries, nor tubes could be differentiated. The mass could also be felt through the rectum.

Extremities were normal, except for some swelling of the feet.

Genito-urinary organs were free from specific diseases.

Neuro-Muscular: The patient is very nervous and worried about her condition. Reflexes are somewhat extenuated. She sleeps well but is easily fatigued.

Menstrual: Menstruation began at the age of twelve; it was the regular, twenty-eight day type, but in later years became profuse, and lasted from five to seven days, using many napkins but she never bled between the periods. She reached the menopause at the age of fifty-two and since then has not seen even a show. The patient was married at the age of twenty, had four children, the first two were instrumental deliveries. No miscarriages or operations.

Laboratory findings: Urinalysis showed the following—specific gravity 1.028, acid reaction, heavy cloud of albumin, no sugar, few hyaline, and fine and coarse granular casts. Wassermann test was negative.

Blood picture: Hemoglobin 80 per cent, r.b.c. 4,000,000, w.b.c. 7,000, polymorphonuclear 67 per

cent, small lymphocytes 31 per cent, large lymphocytes 1 per cent, and eosinophiles 1 per cent.

Pre-operative diagnosis: Large tubo-ovarian cyst or fibroid uterus.

Treatment: under medical and dietetic treatment the kidney conditions cleared up, and the blood pressure dropped to 140/90. Most of her other symptoms disappeared, except for the continuous dull aching pain in the left lower quadrant which was due to the tumor.

Operation: On April 20, 1933, a laparotomy was performed under ether anesthesia. Abdomen was opened by a paramedian incision, and a large fibroid tumor was exposed. Had some difficulty to deliver the tumor out of the side of the abdominal cavity. Classical suprapubic hysterectomy was performed without any incident, except when separating the fibroid from the stump of the cervix, encountered a severe hemorrhage which was coming from the tumor. Abdomen closed without drainage. Patient made a rapid recovery and was able to leave the hospital in fourteen days.

Post-operative diagnosis: Large fibroid uterus. Description of the gross specimen: Tissue consists of a fibroid uterus about 6 x 6 x 6 inches, weighing 4 pounds. Left tube and ovary are intact. A few large blood vessels are scattered over the surface of the tumor. On sectioning, the surface is mottled with large blood spaces containing clotted blood, giving one the impression of multiple adenomata. Some of the spaces are three-fourths inch in diameter, and varying from that size to a pint point size. The interstitial tissue is that of an ordinary uterine fibroid.

Pathological Report: (St. Mary's Hospital, Laboratory, Grand Rapids, Michigan). No. 88261. Microscopical—Sections from the mass removed from the uterus show a number of large vascular spaces filled with blood clots and in many of them there is a papilliferous ingrowth of endothelial cells. Some of them show only an area filled with blood and it is difficult to make out the vessel wall. However, this tumor is a hemangioma of the fibroid uterus. (G. L. Bond.)

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A SELECTIVE TYPE OF THORACOPLASTIC OPERATION

WILLIAM A. HUDSON, M.D.
DETROIT, MICHIGAN

Thoracoplastic operations, as applied in the treatment of pulmonary tuberculosis, are primarily for one of two reasons: (1) To render aid in securing rest for the diseased portion of the lung, or, (2) To aid in the closure of cavities. This use of any surgical procedure in properly selected cases of pulmonary tuberculosis should be considered only as an adjunct in the application of the fundamental principle of rest in the treatment of pulmonary tuberculosis.

Heretofore we have felt that we were sacrificing the function of too much healthy lung tissue when we did a complete posterior thoracoplasty in order to obtain rest for a diseased area in the upper half of the lung field, and we have at times undertaken to limit the resections to those portions of the chest wall adjacent to the diseased lung. Frequently we were greatly disappointed in the end-result. We were disappointed at times even when a resection of the posterior segments of all the ribs was followed by the removal of the anterior ends of a number of ribs because we found that there still remained evidence that would indicate the presence of a cavity that had not been completely closed by this very radical procedure. We have felt that this unsatisfactory result of the more radical operations was due, at least in part, to the fact that by the time the anterior resections were carried out there had occurred considerable regeneration of the posterior stumps with fixation of that part of the chest wall. This prevented one from obtaining a maximum of collapse at the time of the anterior resections. We have made it a practice at all times in preparing for an operation of this sort to begin our thoracoplasty with a resection of segments of the ribs over the diseased area and it has seemed to us that if a complete resection of the ribs over the diseased area could be carried out before any regeneration of the ribs had taken place there would be a better opportunity to obtain a satisfactory collapse of this diseased area. We have hoped that it might be possible to avoid the resection of ribs, or portion of ribs, over the healthy segment of the lung and that it might even be

possible, and safe, to permit such patients to proceed without interference with the function of the phrenic nerve. We have accordingly undertaken such a program and our procedure is, when attacking a lung that shows evidence of disease in its upper portion, to do a resection of one, two, or three, and sometimes four ribs anteriorly from the sterno-costal junction lateralward to the anterior or mid-axillary line. Thus the corresponding anterior segment of the chest wall is freed of its bony support. There is a good separation of the apical portion of the lung in its anterior aspect. The patients are not disturbed by the procedure. We have usually made a skin incision extending from a point just medial to and below the point of the shoulder downward and medialward to the junction of the second or third rib with the sternum. The underlying muscle fibers are separated by blunt dissection. Care has been taken to remove the cartilage and even at times a part of the sternum has been removed. The wound is closed in layers. A drain of gutta-percha without gauze has been placed in a stab wound in the axilla. A small gauze pad is placed in such a manner that it produces mild pressure over the deroofed portion of the lung field. Usually after an interval of seven to ten days we are in a position to proceed with the resection of the posterior ends of these ribs. At this second operation we have taken, as a rule, the first, second, third, and fourth ribs. We find that there is a remarkable caving-in of all structures underlying the field when these posterior segments have been removed. In reality, we find here the appearance that one might expect to find where a very extensive extrapleural pneumolysis has been performed. After the lapse of from ten days to two weeks we are in a position to remove posterior sections of additional ribs if the diseased area has not been put to rest by these first operative procedures. We have found that we can close successfully large cavities in the upper half of the lung field in this manner, and obtain negative sputums for tubercle bacilli, that we were unable to close in the old manner. We feel quit certain that our success to date has been entirely due to the fact that sufficient time has not been permitted to elapse between the first and last operation for fixation of the chest wall to take place, and we feel that it is of utmost importance that the anterior portions of the ribs be removed at the first operation. At the same time it will be borne in mind that we are firm believers in the principles that have led to the use of multiple stage operation and that we have adhered very strictly to these principles. We will admit that it is entirely possible to do a complete resection of the upper three or more ribs through a single posterior incision at a single operation, but we do not feel justified in subjecting our patients to this additional load. At times such complete collapse at a single operation will result in the trapping of secretion in a cavity and can easily end in disaster. Our patients have been in better condition with each succeeding operation than they were when the operative procedures were begun. At no time have we been forced to worry about the welfare of the patient because of shock from the operation. These operations have, for the most part, been carried out entirely under local anesthesia, in fact, in two of our institutions we have not given a general anesthetic for a thoracoplastic operation in the past two years. There is one question which may be brought up in the minds of certain of the readers; that is the question as to whether or not the marked collapse of the upper half of the chest may bring about crowding at the base of the heart to such an extent that it will interfere with the heart action. We have not seen evidence of any disturbance of the heart action. The electrocardiographic studies, so far carried out, have not indicated that any disturbance has taken place. We are continuing these observations and will present a detailed report in a later paper dealing with this type of operation.

It is our desire to bring to your attention at this time a selective type of thoracoplastic operation by means of which one can, with a reasonable degree of safety, produce closure of large cavities and collapse extensively diseased portions of the lung without unduly sacrificing healthy lung tissue. We would recommend this procedure:

1. Because it is possible to conserve healthy lung.
2. Interference with the function of the phrenic nerve can be avoided in many cases.
3. The procedure can be carried out in multiple stages.
4. Collapse of large cavities can be produced without shock to the patient.
5. Gross bodily deformity is less marked.

MICHIGAN'S DEPARTMENT OF HEALTH

C. C. SLEMONS, M.D., Dr.P.H., Commissioner
LANSING, MICHIGAN

ABOUT BIRTH CERTIFICATES

The State Department of Health urges that greater care be exercised by physicians in the preparation of birth certificates. An endless number of certificates are returned to the Department because the name is wrong, or improperly spelled, or the wrong date entered. Physicians as a group have not been noted for their penmanship, and many of the errors are due to the fact that the names are so carelessly written that they cannot be deciphered. The photostat process is now used for making certified copies, and it is probable that some physicians would be a good deal embarrassed if they were called to the witness stand to decipher certificates bearing their name.

The most satisfactory certificate is one that is typewritten in full, including the name of the attending physician, and then signed by him.

Another thing that is most unfortunate is that the question as to legitimacy is frequently left blank. The Department always assumes that where this is blank the child is legitimate, but it is not fair either to the child or to his parents to leave it blank since the question might very properly be raised at some time in the future as to why this was not filled out. In other words, it leaves a doubt as to the legitimacy of the child.

Under the new law, birth certificates of illegitimate children are to be filed directly with the State Department of Health and not with the local registrar.

COMMUNICABLE DISEASE NOTES

Last month we discussed the existing trend of diphtheria incidence. Diphtheria continues to be a little higher than the expectancy, considering the season and the sharp downward curve for several years past. There are, however, relatively few cases and no great number is expected before fall or winter.

The incidence of typhoid fever is considerably below that of last year. Nearly all cases occurring in 1933 have been sporadic. In 1932 there were a number of small outbreaks which brought up the rate. The usual seasonal increase has not yet made itself apparent but may be expected during August and September.

Scarlet fever is running lower than the usual low seasonal incidence. This is the first time during the year that the rate has been below the norm.

DR. BECKETT APPOINTED FIELD AGENT

Dr. M. B. Beckett, former Health Officer of Isabella County, has been appointed as County Field Agent for the Michigan Department of Health. Much of his time will be given to a study of the full-time county and district health departments.

VISITORS

The Rockefeller Foundation has sent to the Michigan Department of Health a number of their Fellows who have been students at either Harvard or Johns Hopkins Schools of Public Health, to study the work of the department and of the various county health departments. These men have spent varying periods of time with us, from a few days up to six weeks. We list the visitors:

Dr. K. K. Huang, Acting Chief, Central Hospital, Nanking, China.
Dr. M. Djamil, Member of the Netherlands East Indies Health Service, Java.
Dr. S. Harashima, Instructor in Physiology, Keio University Medical School, Tokyo, Japan.
Dr. L. M. Watson, Parochial Health Officer, Jamaica.
Dr. A. L. Gray, from Mississippi.
Dr. E. K. Musson, State Department of Health, Jefferson City, Missouri.

CHILD HYGIENE NOTES

The series of Women's Classes conducted in Oakland County by Dr. Ida Alexander has been completed. A new series was begun in Lapeer County Monday, July 31.

Infant Welfare Programs in Mason and Leelanau Counties, carried on by Julia Clock, R.N., have been concluded.

Martha Giltner, R.N., has finished a six months' Prenatal Nursing service in Mid-

land County, where she went at the request of the County Health Officer, Dr. A. W. Newitt. From Midland she went to Isabella County, where she will give six months' service developing a Prenatal Program at the request of Dr. T. E. Gibson, County Health Officer.

The county nurse in Ontonagon County is being assisted by Annette Fox, R.N., in developing an Infant and Maternal Welfare Program. Calls are being made on prospective mothers and mothers of young infants, and certificates of registration of birth are being delievered to parents of newborn babies. Miss Fox will remain in Ontonagon County the balance of the summer.

Nell Lemmer, R.N., has started an Infant Welfare Program in Iron County, and Bertha Cooper, R.N., is conducting a similar program in Clare County.

OSTEITIS FIBROSA CYSTICA OF THE SKULL WITH HEMIANOPIA AND PSYCHOSIS*

Harold D. Palmer, Reed Harrow and Louis A. Schwartz relate the case of a Jewish girl, fourteen years old, who had sustained a fracture of the occipital bone at the age of two years. At the age of nine, a change of personality occurred which by the age of twelve had assumed psychotic proportions. A bone defect was noted in the occipital region at the age of twelve and was confirmed by a roentgenologic study two years later. The lesion was diagnosed as localized osteitis fibrosa cystica. The mental symptoms became so pronounced that confinement in a psychiatric institution was necessary.

Predominating symptoms were headache, apathy, depression, a sense of unreality, dream states, and periods of amnesia and abstraction of varying duration, during which the patient heard voices and experienced visual hallucinations of a vague nature. The patient recognized these abnormal phenomena and showed insight into her condition. The mood was one of depression and anxiety; there was a pronounced suicidal trend, and a history of attempts by poison. Neurologic examination showed the presence of left homonymous scotomas, which suggested a bilateral lesion of the macular bundle pointing to a focal lesion at the calcarine cortex of the right occipital pole. Pressure of bone cyst was believed to be the cause of origin of the hallucinatory phenomena and the homonymous scotomas. A right occipital craniotomy was performed, and the protruding inner wall of the large cyst removed. Postoperative observations showed a pronounced change in mood with a complete disappearance of the hallucinations and subsidence of the mental symptoms. The basal metabolic rate was as low as twenty-eight prior to operation and the blood calcium was 8.8 mg. per 100 c.c.

In their summary, the authors state that the case reported is one of localized osteitis fibrosa cystica, resulting from an injury to the skull in infancy and giving rise to neurologic symptoms twelve years after the occurrence of the trauma. The etiologic part of the trauma is significant since recent literature has tended to designate the generalized form as dependent on the parathyroid hyperplasia and the local type as determined purely by trauma. Yet it is obviously rare that bone injury leads to the formation of cystic areas of osteitis. In the light of recently established relationship between endocrine imbalance and the malacias, it may be conjectured that there are conditioning endocrine factors in patients who develop cystic bone lesions following trauma, resulting in disordered metabolism and predisposing to anomalous repair with typical cyst formation.

Focal compression of the right occipital pole by the intrusion of the inner wall of the bone cyst produced a lesion of the calcarine cortex, evidenced by the incomplete left homonymous hemianopia. Irritation of the visual cortex in this area occasioned visual hallucinatory phenomena. The similarity between the picture presented by this patient and that of patients with tumors of the occipital lobe is worthy of emphasis. The differential diagnosis rested largely on the roentgenologic observations.

*This article was published in the Arch. Neurol. and Psychiat. (January), 1932, 27:45.

POSTOPERATIVE PULMONARY COMPLICATIONS: STUDY OF THEIR RELATIVE INCIDENCE FOLLOWING INHALATION ANESTHESIA AND SPINAL ANESTHESIA

A. LINCOLN BROWN and MARTIN WARREN DEBENHAM, San Francisco, present statistics showing the relative incidence of postoperative pulmonary complications following inhalation anesthesia and subarachnoid anesthesia. In their series of 812 cases, postoperative pulmonary complications were 4.29 times more frequent after subarachnoid anesthesia than after inhalation anesthesia in spite of the fact that more "bad risk" patients were operated on under inhalation anesthesia. The adverse ratio for subarachnoid anesthesia was found regardless of the region of the body operated on or the type of operation performed. The more closely the operative procedure approached the diaphragm, the greater was the incidence of postoperative pulmonary complications.—*Journal A. M. A.*

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SEPTEMBER, 1933

"I hold every man a debtor to his profession, from the which as men of course do seek to receive countenance and profit, so ought they of duty to endeavor themselves, by way of amends, to be a help and ornament thereunto."

—Francis Bacon

EDITORIAL

BUSINESS IN THE PRACTICE OF MEDICINE

That is the subject upon which Father Alphonse M. Schwitalla, S.J., Dean of the St. Louis University School of Medicine, will speak to delegates, officers and members who are present at 10 a. m. on Tuesday, September 12, in the Ball Room of the Pantlind Hotel.

Father Schwitalla has gained the respect and confidence of the profession by the manner in which he has fearlessly attacked the attempts to foist upon the profession various types of supervised practice. He has participated in many conferences upon the subject. He has addressed large audiences in many parts of the country. He has upheld the profession in its efforts to provide adequate medical care. He is a forceful, eloquent speaker.

Our Society is fortunate and privileged in securing this notable person to participate in our annual program. Every member who possibly can should hear this address. It can be safely stated that a clearer insight will be had of the problems that confront every doctor, and helpful suggestions will be made. We urge that you arrange to be present.

Appended are some of the gentleman's affiliations:

SCHWITALLA, ALPHONSE MARY, clergyman, zoologist; b. Beuthen, Upper Silesia, Germany, Nov. 27, 1882; s. Peter J. and Pauline (Welzel) S.; came to U. S., 1885; A.B., St. Louis U., 1907, A.M., 1908; Ph.D. in Zoology, Johns Hopkins, 1921 Joined Jesuit Order, 1900; ordained priest R.C. Ch., 1915; instr. chemistry, St. Xavier Coll., Cincinnati, 1907-10; instr. biology, Rockhurst Coll., Kansas City, Mo., 1917-18; asso. prof. biology, St. Louis U., 1921-24; prof. biology and dir. Dept. of Biology, St. Louis U. since 1924, dean Sch. of Medicine, 1927, dean Sch. of Nursing, 1928, regent Sch. of Dentistry. Pres. Catholic Hosp. Assn. U. S. and Can., 1928; pres. Missouri Social Hygiene Association. Major Chaplains' Reserve, U. S. A. Contrb. on philosophy of biology, investigations on environment of organisms, ameboid movement, etc. Mem. A.A.A.S., Ecol. Soc., St. Louis Acad. Science, Am. Soc. Zoology, Anthrop. Soc. America, Phi Beta Kappa, Sigma Xi, Alpha Omega Alpha, K.C. War Chaplain, Kansas City, Mo., 1918-19. Home: 221 N. Grand Av., St. Louis, Mo.—From *Who's Who in America,* Vol. 17, 1932-1933, p. 2044.

MAKING THE MOTORIST RESPONSIBLE

On October 16, 1933, the Financial Responsibility Law making the drivers of motor cars responsible for any accident caused by them, will go into effect. This law was passed by the last legislature. Its object is to make the wreckless drivers pay for any damages done by them. At present the cautious driver carries a policy covering personal liability and property damage, so that the victim of accident caused by his car may have redress. The careless driver has felt that since he had nothing, nothing could be collected from him and so he goes his way. The law will make even the uninsured motorist responsible for any damage done. After a court trial and verdict rendered he will be compe'led to pay for the damages found against him. If he does not comply with these requirements the penalties are stated as fo'lows: 1. He cannot drive an automobile again in Michigan. 2. All license p'ates for cars issued in his name are withdrawn and the cars cannot again be

licensed while owned by him, nor can he transfer them except by bona fide sale. 3. He shall be unable to license any new car that he may purchase.

This is a much needed law which should insure the safety of the public. Similar legislation is in operation at the present time in many states of the Union and provinces in Canada. It will doubtless work a certain hardship to some motorists but no hardship to the individual should be allowed to outweigh the safety of the public.

BIRTH CERTIFICATE

We have published each month a contribution from the Commissioner of Health at Lansing which we presume has been generally read. This department is condensed and authoritative and affords the profession an opportunity for a monthly budget of news directly from the State Health Department.

Among the items which appear this month is a plea on the part of the commissioner for greater accuracy in the filling out of birth certificates. It is a matter of great importance legally that all names should be accurately written and that the legitimacy of the child should not be left in doubt. Where the matter of domestic relations is concerned or the inheritance of property, this feature alone is of paramount importance if an injustice to some one at some later time is to be avoided.

SWEDISH MEDICAL HISTORY

Among the contributions in this number of the JOURNAL is the paper on Six Centuries of Medical Progress in Sweden by Dr. B. H. Larsson of Detroit. This paper on medical history is out of the ordinary. It is unusual to have the opportunity of publishing a paper that is wholly Scandinavian in its scope. It is authoritatively written by one of our own members who was born in Sweden and who was largely educated there except for his medical education which was obtained at the Detroit College of Medicine and Surgery. We commend this paper to the increasing number of our members who are interested in the history of medicine. Dr. Larsson speaks and writes Swedish fluently so that his history is based upon a first hand study of Swedish medical documents as well as correspondence with some of the present day leaders in Swedish medicine.

THE EXPERT WITNESS

With the increasing stress of the depression there is a tendency among workers injured during employment to seek to reopen their alleged claims which have been disallowed. Here the doctor is called upon to assume an important rôle as expert witness. From the legal viewpoint any doctor may qualify as expert, regardless of whether he is a specialist in the subject in which he is called to enlighten the court. If, however, the opposite party to the suit calls in a witness who by years of experience or by limitation of his attention to the particular phase under question, the testimony of the person who possesses only a general knowledge of the subject is apt to be heavily discounted in the minds of the jury.

Repeating what we have said before, the medical expert witness cannot appear as an advocate. His attitude must be that of the scientist whose quest is truth. He may be compelled by circumstances even to oppose the plaintiff or defendant who may have called him. We have felt that the ends of justice might be better conserved were the court to appoint and to recompense the "expert," and thereby assure testimony that is free from any suspicion of partisanship. This would do away with a custom that frequently leaves the plaintiff's experts without remuneration and gives the pecuniary advantage to the defendant's expert. So common is the custom of some lawyers to take a case on a percentage basis—usually a very large percentage—and to requisition the services of the doctor as expert, without even the ordinary witness fee, that many doctors show little enthusiasm in the matter of appearing in court. True medical testimony is non-partisan; viewed in its true light the scientific witness would not be looked upon as he so frequently is, by the legal profession as a poor witness. A good witness from the legal viewpoint is evidently a cocksure witness. The scientifically minded person is seldom that.

GENERAL PRACTICE VERSUS SPECIALISM

(New England Journal of Medicine)

The general practitioner seems at last—or again—to be coming into his own. The old-fashioned family doctor with a Boston in lieu of a saddle-bag is about to ride into harbor on a high tide of renewed popular sentiment, if general wishes are in truth fathers of accomplished facts. Not long ago a rare

collection of representatives of the genus was exhibited in order to stimulate the emotions and relax the purse strings of the general public; the motive was worthy and the applause which thundered at the time is even now reëchoing with increased volume from the elevated rims with which every depression must be surrounded.

Any movement to replace the general practitioner in his accustomed sphere of unparalleled usefulness deserves our heartiest approbation and should win our active support. At his best—and we have all known and still know him at his best—he is an indispensable part of the sturdy organization of our highest type of community and family life, loved, respected and honored. At his worst he is no better than the worst in any other respectable field of activity. Let us do honor to the family doctor, but let us do it with the minimum of maudlin sentimentality which our national characteristics demand. The general practitioner, with a decent amount of encouragement, support and advertisement (not self-advertisement) will win exactly the place in the life of the community which he deserves, personally and according to the laws of economic demand.

THE CONVENTION AT GRAND RAPIDS

Weel.—We'll soon be haein' a meetin'
'Way doon near Rapids grand,
An' we'll hae a freen'ly greetin'
Frae th' hale Gran' Rapid's band.

We'll be sittin' near th' river,
Near th' temptin' flowin' bowl,
We'll be greeted warm an' clever,
As we members sign th' roll.

Delegates wull hae contention,
Guid an' hot wull be some pairts,
Bit th' scientific session,
Wull be warmin' tae oor hearts.

Ther'll be talks o' tonsilitis,
Belly pain an' abscess stitch,
An' ther'll be some gosh almichties,
Wi' some stuff tae cure th' itch.

Of course, we'll hae allergia,
'Sae much, 'twull mak us sneeze,
An' we'll hear about ataxia,
That cam frae haein' a squeeze.

Bit Oh, th' joy o' fellowship
Wi' freen's frae o'er th' State,
Are blessin's o' oor membership,
Far mair than ah can state.
Ah well. Guid Nicht,

WEELUM.

HEAVILY FILTERED HIGH VOLTAGE ROENTGEN IRRADIATION IN CANCER THERAPY

WALTER L. MATTICK, Buffalo, outlines briefly his experiences of the past four years with what he characterizes as a type of short wavelength therapy, previously referred to as protracted radiation, carried on with the usual 200 kilovolt X-ray equipment in which heavy filtration (3 mm. of copper) has been substituted for the usual 0.5 mm. of copper as commonly used in the average routine roentgenotherapy of the present day. During the past four years he has administered approximately 500 such treatments to fifty-two patients with various types of malignant growths. Most of these cases were far advanced or of the ordinarily refractory types. In this category are included the following: forty-two patients with cancer of the breast (mostly far advanced), four with cancer of the larynx, four with cancer of the esophagus, one with epithelioma of the oral cavity and one with epithelioma of the cervix (far advanced). In evaluating the results thus far attained the author is in full accord with Schreiner, for many years chief surgeon at the State Institute, who refers to this heavily filtered shorter wave roentgen and teleradium therapy as the most promising types so far advanced, besides having decided advantages in treatment and producing quite similar results on the malignant conditions in which it has so far been used.—*Journal A. M. A.*

AN ORTHOPEDIC PROBLEM

High-heeled shoes and silk stockings may eventually make a race of women with hooves instead of feet, says Dr. Clifford I. Groff, of London. With apologies therefore to the dear doctor and to Henry Wadsworth Longfellow—

Art is long and time is fleeting,
And our hearts, though stout and coarse,
Dread the day when women, bleating,
Gallop like the sheep or horse.

Lives of women all remind us
We can make our lives sublime.
But why go and leave behind us
Hoofprints on the sands of time?

Let them, then, be up and doing,
Lower heels and thicker socks.
Knees and ankles are much nicer
Than an equine's hooves and hocks.

—*Border Cities' Star.*

RENAL RICKETS

According to ARTHUR R. ELLIOTT, Chicago, there exists a form of rickets developing in childhood in association with, and apparently as a result of, chronic nephritis. Other causes of persistent renal insufficiency, such as congenital cystic kidney and double hydronephrosis, may effect the same result. Bodily development is markedly retarded and, when the patient survives beyond the age of puberty, sexual infantilism may exist. Chemical studies of the blood reveal an increasing azotemia coinciding with the increasing excretory inadequacy of the kidney. Strangely enough, the blood pressure is not elevated until perhaps just before death. With the high concentration of blood nitrogen, there may be manifestations of uremia. Death usually results from the kidney insufficiency. Roentgen studies of the bony structure disclose the typical appearance of rickets. Genu valgum is the principal manifestation of the pathologic bone condition and may be the first symptom to call attention to the underlying kidney condition.—*Journal A. M. A.*

OFFICIAL PROGRAM

113th Annual Meeting Michigan State Medical Society

September 11, 12, 13 and 14, 1933

OFFICIAL CALL

The Michigan State Medical Society will convene in annual session in Grand Rapids on September 11, 12, 13 and 14, 1933. The provisions of the Constitution and By-Laws and the official program will govern the deliberations.

J. MILTON ROBB, *President*
B. R. CORBUS, *Chairman Council*
H. J. PYLE, *Speaker*

Attest:
F. C. WARNSHUIS, *Secretary*

INFORMATION

MEETING PLACES

House of Delegates—Pantlind Ball Room.
Section Meetings—Civic Auditorium.
Medicine.....Main Ball Room
Surgery.....Stage—Main Auditorium
Gynecology & Obstetrics.....
Committee Rooms "B" to "E" Main Floor
Pediatrics.....Red Room—Second Floor
Dermatology..Committee Room "F" Main Floor
Eye, Ear, Nose & Throat.....
Ball Room—Pantlind Hotel
Combined Sections.....
Main Ball Room—Auditorium

General Meeting—Civic Auditorium.
Combined Section Meetings—Civic Auditorium.
Exhibits—Civic Auditorium.
Registration—Civic Auditorium.

Time—Daylight Saving.
Council Meeting—September 11, 11:00 A. M.

General Meeting

Wednesday Evening—Sept. 13, 1933—7:45 P. M.

CIVIC AUDITORIUM

Presiding: J. MILTON ROBB, M.D., President—Detroit.

1. Musical Prelude—7:30-7:45 P. M.
1A. Invocation: Rev. J. W. Fifield, Jr.
2. Welcome—H. J. Pyle, M.D., President, Kent County Medical Society.
3. Announcements—F. C. Warnshuis, M.D., Secretary.
4. President's Address—"Our One Great Undepressed Asset."—J. Milton Robb, M.D., Detroit.
5. Address—"American Medicine in Relation to the National Recovery Act"—E. H. Cary, M.D., Dallas, Texas, retiring President, American Medical Association.
6. Induction Into Office as President—George L. LeFevre, M.D., Muskegon.
7. Introduction of President-Elect.
8. Adjournment.

Combined Section Meetings

First Session—Wednesday, Sept. 13, 1933

1:15 P. M.

Presiding: Section Officers.

1. "Differentiation of Common Endocrine Disturbances"—Dr. R. H. Moehlig, Detroit.
2. "Physiological Functions of the Gastro-intestinal Tract"—Dr. Wingate Todd, Cleveland, Ohio.
3. "The Surgical Aspects of Syphilis"—Dr. Udo J. Wile, Ann Arbor.
4. "Diseases of the Colon"—Dr. Thomas E. Jones, Cleveland.

CONDENSED DAILY SCHEDULE

Monday, September 11	Tuesday, September 12	Wednesday, September 13	Thursday September 14	Memorandum
10:00 A. M. Executive Committee 11:00 A. M. Council	9:30 A. M. House of Delegates	9:15 A. M. Section Meetings Medicine Surgery Gynecology and Obstetrics E.E.N.T. Pediatrics Dermatology	9:15 A. M. Section Meetings	1. Registration in Exhibit Hall Auditorium 2. All Sessions in Auditorium except E.E.N.T. 3. E.E.N.T. in Ball Room Pantlind Hotel 4. House of Delegates, Pantlind Ball Room 5. See Bulletin Board for Rooms Assigned to Sections. —o—
Afternoon	Afternoon	Afternoon	Afternoon	
2:00 P. M. House of Delegates	2:30 P. M. House of Delegates	1:15 P. M. Combined Sections	1:15 P. M. Combined Sections	
7:30 P. M. House of Delegates	7:30 P. M. House of Delegates	7:45 P. M. General Meeting President's Address Invited Guests	Invited Speakers	Do not fail to visit Commercial and Scientific Exhibits in the Auditorium

Second Session—Thursday, Sept. 14, 1933

1:15 P. M.

1. "The Rôle of the Urologist in General Diagnosis"—Dr. Herman L. Kretschmer, Chicago, Ill.
2. "Practical Application of Orthopedic Principles"—Dr. Willis Campbell, Memphis, Tenn.
3. "An Analysis of over 100,000 Births in Iowa with Particular Reference to the Relationship between Type of Delivery and Stillbirth"—Dr. E. D. Plass, Iowa City, Iowa.
4. "Blood Chemistry in Medicine (Calcium, Sugar, Nitrogen, etc.)"—Dr. Wilbur Post, Chicago, Ill.

SECTIONAL PROGRAMS

General Medicine

Chairman: I. W. GREENE, Owosso.
Secretary: S. MERRILL WELLS, JR., Grand Rapids.

First Session—Thursday, Sept. 13, 1933

9:15 A. M.

1. Chairman's Address—"The Unimportance of Being an Internist"—Dr. I. W. Greene, Owosso.
2. "Some Basic Principles in the Treatment of Cardiac Failure"—Dr. M. S. Chambers, Flint.

   Mention will be made of the heart as a physiological unit in a system of organs designed to transport oxygen and carbon dioxide to and from the tissues. The mechanism of cardiac failure will be briefly discussed. The various accepted methods of treatment will be reviewed, with special emphasis placed on the therapeutic rationale of these procedures.

   Discussion—
   1. Dr. Paul Barker, Ann Arbor.
   2. Dr. Norman Clark, Detroit.
3. "Resocialization Following Modern Therapeutic Measures for the Treatment of Paralytic Dementia"—Dr. P. V. Wagley, Pontiac.

   Discussion—
   1. Dr. R. A. Morter, Kalamazoo.
   2. Dr. P. R. Sheets, Traverse City.
4. "Functional Disturbances of the Colon" (Illustrated by lantern slides)—Dr. E. L. Eggleston, Battle Creek.

   An appreciation of functional disturbances of the colon has been called to the attention of the profession by numerous observers; nevertheless, a better understanding of the function of the sympathetic and parasympathetic nervous innervation is desirable.
   Psychic disturbances are undoubtedly of great importance in producing an instability of the innervation of the colon.
   A brief review of certain cases specifically illustrating functional disturbances.

   Discussion—
   1. Dr. J. G. Mateer, Detroit
   2. Dr. J. B. Jackson, Kalamazoo.
5. "Medical Participation in Public Health"—Dr. Stuart Pritchard, Medical Director, W. K. Kellogg Foundation, Battle Creek, and Dr. Henry F. Vaughan, Commissioner of Health, Detroit.

   In spite of the present stress and strain, death rates throughout the country have continued to fall. The American people have at least been blessed with good health. The medical and dental professions have played a dominant part in establishing this salubrious condition. In order to conserve the gains which have been made in public health, the family physician must be firmly re-established as the individual to whom the public will turn for services in preventive and curative medicine.
   Medicine remains an art, the fullest appreciation of which is dependent upon the close relationship between the individual and the family medical advisor. Any plan for dispensing medical service should be promulgated and controlled by organized physicians and dentists. Preventive medicine affords a unique opportunity for re-establishing the family physician who, through service to the well, is better prepared to care for the ill. Machine-age methods are not applicable in medicine, where a knowledge of the individual's physical and mental handicaps prepares the professional man for optimum service to his client.
   During the past several years there has been developed in Michigan a program whereby the family physician becomes an active participant in the practice of preventive medicine, and many prophylactic services which were previously rendered by health departments have been transferred as an obligation to the coöperating physician in his own office. The advantages of such a plan are obvious. In the prevention of diphtheria free clinics have been eliminated and in other fields their influence has been minimized. The status of the family physician has been established. A large group being able to do more work than a small one, the efficiency of the medical care has been increased, more work has been accomplished, the cost has been equitably distributed, the physician has been compensated for service to indigents, the cost of preventive care to the community has been reduced and the budget of the health department has been conserved. A more enduring relationship has been developed and sustained between the profession, the public and the health department. The health department has confined its activities to supervision, health education and police control of communicable diseases. Significant reductions have been made in the incidence of such preventable diseases as diphtheria and smallpox and the family has been encouraged to turn to the physician for their periodic health examination, for the investigation of other departures from normal health and for the correction of impeding physical and mental handicaps.
   The development of such a plan of medical participation is dependent upon a sympathetic understanding between the organized professions and the health agencies. The professional man must be prepared to render a definite service, and the health agency must educate the public to the value of the service which the physician and dentist is able to offer. The practice of preventive medicine pays large dividends to the public, to the physician and dentist, and to the health agency.

   Discussion—
   1. Dr. F. B. Miner, Flint.
   2. Dr. R. H. Holmes, Muskegon.

Second Session—Thursday, Sept. 14, 1933

9:15 A. M.

1. "Subacute Bacterial Endocarditis"—Dr. Frank N. Wilson, Ann Arbor.

   Discussion—
   1. Dr. W. H. Marshall, Flint.
   2. Dr. E. D. Spaulding, Detroit.
2. "Primary Cancer of the Bronchus and Lung"—Dr. Willard D. Mayer, Detroit.

   The paper consists of a description of the symptoms, pathology and physical signs of primary cancer of the bronchus and lung. The marked variation in symptomatology and physical signs is presented along with the various diagnostic procedures employed in arriving at a diagnosis. The importance of early diagnosis and treatment is emphasized. Statistics of cases seen at Harper Hospital are presented. The histories of four cases are presented, one a possible cure. Lantern slides of these cases will be shown.

   Discussion—
   1. Dr. Vernor M. Moore, Grand Rapids.
   2. Dr. Wm. Evans, Detroit.
3. "Types of Nephritis and Their Treatment"—Dr. Wilber E. Post, Chicago.

   Discussion—
   1. Dr. Wm. Northrup, Grand Rapids.
   2. Dr. F. H. Lashmet, Ann Arbor.
4. *Pathological Conference* led by Dr. Wm. German, Grand Rapids, with interested clinicians leading discussion, etc.

Surgery

Chairman: GEORGE J. CURRY, Flint.
Secretary: HAROLD K. SHAWAN, Detroit.

First Session—Wednesday, Sept. 13, 1933

9:00 A. M.

1. "Abscess of the Lung"—Dr. John Alexander and Dr. Cameron H. Haight, Ann Arbor.

   The gravity of abscess of the lung frequently depends upon early recognition and intensive treatment. The timely use of appropriate non-surgical measures often

cures the early stages of the disease. The chronic advanced stages stubbornly resist the simpler therapeutic procedures and then surgery offers the best chance of cure. The various means of treatment that have been found to be effective will be presented.

Discussion—

1. Dr. E. J. O'Brien, Detroit.
2. Dr. William A. Hudson, Detroit.
3. Dr. W. H. Alexander, Iron Mountain.

2. "Pulmonary Complications following Anesthesia"—Dr. Clark Lemley, Detroit.

The data presented cover a survey of various types of anesthesia used over a period of two years, 1931-1932. There are approximately six thousand cases to be drawn from. The discussion leads into the theories and possible factors involved in production of the various types of pulmonary complications. Comparative statistics will be presented, as well as statistical data on the types of complications, their incidence, the mortality, and the methods of treatment employed in the various conditions.

Discussion—

1. Dr. B. H. Van Leuven, Petoskey.
2. Dr. W. A. Manthei, Lake Linden.

3. "A Discussion of Gall Bladder Disease and Its Management"—Dr. Henry J. Vanden Berg, Grand Rapids.

Patients who continue to seek relief for trouble of gall-bladder origin should not be treated medically indefinitely. They should be given the benefit of surgery. One's conception of gall-bladder disease should not be limited to the gall bladder. It should embrace the liver and pancreas which may become involved through direct extension. In fact all parenchymatous tissues, notably the heart and kidneys may become affected. Cases well selected, or probably better said, well diagnosed before surgery, those well operated on and those that have not been neglected too long can be given the promise of results that are as good as any obtained in surgery.

Discussion—

1. Dr. C. E. Boys, Kalamazoo.
2. Dr. G. A. Seybold, Jackson.

4. "Thyroid Surgery in Southern Michigan as Affected by the Generalized Use of Iodized Salt"—Dr. Roy D. McClure, Detroit.

There has been a great reduction in the incidence of non-toxic diffuse goiter in Southern Michigan since the introduction of iodine salt. It would appear from the experiences here reported that if the thyroid iodine balance can be maintained that also toxic diffuse and nodular goiters are less apt to develop.

Discussion—

1. Dr. Simon Levin, Houghton.
2. Dr. Frederick A. Coller, Ann Arbor.

5. "Clinical Abdominal Diagnosis"—Dr. T. G. Yeomans, St. Joseph.

Experience has shown the importance of clinical diagnosis. Differentiation between diagnosis with all the scientific aids and the old fashioned method by observation, correlation of symptoms and logical deductions. Is the art of clinical observation and deduction being lost?

Discussion—

1. Dr. Alex. J. MacKenzie, Port Huron.
2. Dr. Julius H. Powers, Saginaw.

6. "End Results of Arthoplasty of the Hip"—Dr. Willis C. Campbell, Memphis, Tenn.

An analysis of 127 arthroplasties of the hip is reported. In unilateral ankylosis acute pyogenic infection is the most frequent etiologic factor; in bilateral ankylosis the etiologic factors are usually acute pyogenic infection and low grade progressive polyarticular arthritis. Arthroplasty of the hip is indicated in all monarticular affections after the process has subsided, with the exception of tuberculosis. Arthroplasty in bilateral ankylosis is successful in selected cases. The operative technic and postoperative care are described in detail.

Discussion—

1. Dr. F. C. Kidner, Detroit.
2. Dr. John T. Hodgen, Grand Rapids.

Second Session—Thursday, Sept. 14, 1933
9:00 A. M.

1. "Treatment of Peritonitis Associated with Appendicitis"—Dr. Frederick C. Coller and Dr. Eugene B. Potter, Ann Arbor.

A study is made over a three-year period of patients with general peritonitis associated with appendicitis. Comparison is made of the mortality and morbidity in a group treated by conservative measures (Ochsner regime) and delayed operation, and those previously treated by immediate appendectomy with drainage. The end results and greatly reduced death rate indicate that delayed operation is of the greatest importance in the management of late appendicitis with diffuse peritonitis.

Discussion—

1. Dr. Frederick C. Warnshuis, Grand Rapids.
2. Dr. Earl I. Carr, Lansing.

2. "Surgery of the Diabetic Patient"—Dr. C. Fremont Vale, Detroit.

Surgery in diabetic patient, either elective or essential, increasing. Coöperation between internist and surgeon necessary. Fundamentals of disturbed metabolism surgeon must know. Their relation to surgical case. Preparation of patient for operation. Operative precautions. Postoperative measures. Gangrene.

Discussion—

1. Dr. Richard M. McKean, Detroit.
2. Dr. R. L. Mustard, Battle Creek.
3. Dr. B. R. Corbus, Grand Rapids.

3. "Fractures of the Pelvis"—Dr. Harry B. Knapp, Battle Creek.

The apparent inaccessibility of the pelvic bones and the frequency of fractures today make this subject one of importance. While apparently inaccessible methods of modern diagnosis have brought practically all parts of the pelvis structure within the diagnostic field, most pelvic fractures are simple and occur without involving the pelvic viscera. Shock is an important symptom and varies in proportion to the visceral involvement. Diagnosis of bladder rupture must be based on other findings than blood in urine. Cystoscopic examination with sodium iodide injection, or air injection, followed by x-ray is the only sure method. Prompt operation in presence of ruptured bladder is imperative. Central dislocation of the head of the femur through fracture of the acetabulum requires special reduction procedures to withdraw head and keep in place with lateral as well as longitudinal traction. Bladder rupture may be intra- or extraperitoneal, and must be dealt with accordingly. Foot-drop is an occasional complication due to injury of lumbosacral cord. Treatment and after care are important, and the end result generally good.

Discussion—

1. Dr. Thomas V. Carney, Alma.
2. Dr. R. W. McGregor, Flint.

4. "Changing Trends in the Treatment of Prostatic Obstruction." (Lantern slides)—Dr. Herman R. Kretschmer, Chicago, Ill.

Discussion—

1. Dr. H. W. Plaggemeyer, Detroit.
2. Dr. Alvin Thompson, Flint.

5. "Carcinoma of the Breast"—Dr. Thomas E. Jones, Cleveland, Ohio.

This paper deals briefly with the diagnosis of carcinoma of the breast. How early can it be diagnosed? Is it wise to leave any tumor alone?

There appears on the horizon an oncoming wave of conservatism which I believe will prove disastrous. Too much attention has already been paid to cosmetic rather than curative results.

The radical operation described. Relative value of x-ray therapy. Statistics and end results.

Discussion—

1. Dr. Richard R. Smith, Grand Rapids.
2. Dr. William E. Shackleton, Kalamazoo.

Gynecology and Obstetrics

Chairman: NORMAN F. MILLER, Ann Arbor.
Secretary: HAROLD C. MACK, Detroit.

First Session—Wednesday, Sept. 13, 1933
9:00 A. M.

1. Chairman's Address—Dr. Norman F. Miller, Ann Arbor.
2. Report of Committee on Clinical Problems—Dr. Ward Seeley, Detroit.
3. "The Treatment of Primary Dysmenorrhea"—Dr. L. E. Bauer, Detroit.
4. "Conservative Treatment of Placenta Previa"—Dr. Ward Seeley, Detroit.

The management of placenta previa, exclusive of cesarean section, is illustrated in a series of cases. Good results can be obtained with patients in poor condition, or in patients where previous manipulations or well-advanced cervical dilatation render cesarean section inadvisable. The importance of preliminary blood transfusion for the reduction of mortality is stressed. Methods of treatment advised include (1) artificial rupture of membranes, (2) Braxton-Hicks version, (3) insertion of dilatable bag. The dangers of *accouchement forcé* are emphasized.

5. "Ovarian Disease in Relation to the Painful Breast"—Dr. J. E. Rosenfeld, Battle Creek.
6. "Hemorrhage from Ruptured Graafian Follicle Cysts with Case Reports"—Dr. S. L. LaFever, Ann Arbor.

Second Session—Thursday, Sept. 14, 1933
9:00 A. M.

1. Business Session—Election of Officers.
2. Report of Section Committee on Birth Control—Dr. Harold Mack, Detroit.
3. Report of Committee on Birth and Death Certificates—Dr. Russel Alles, Detroit.
4. "Toxemias of the Later Months of Pregnancy"—Dr. A. Dale Kirk, Flint.
5. "The Effect of Labor Upon the Kidneys of the Pregnant Woman"—Dr. J. E. Cooper, Battle Creek.

   The paper will be divided into four subdivisions, namely, (1) eclampsia, which will probably not be discussed, (2) chronic nephritis and (3) the milder forms of renal fatigue so-called, (4) the upper urinary tract dilatations, including pyelitis.
6. "The Forceps in General Practice"—Dr. E. D. Plass, Prof. of Obstetrics and Gynecology, University of Iowa, Iowa City, Iowa.

   The speaker for the general session will be Dr. E. D. Plass. His title will be—"An Analysis of over 100,000 Births in Iowa with Particular Reference to the Relationship between Type of Delivery and Stillbirth."

Otolaryngology and Ophthalmology

Chairman: CARL C. MCCLELLAND, Detroit.
Secretary: RALPH B. FAST, Kalamazoo.

First Session—Wednesday, Sept. 13, 1933
9:15 A. M.

Ophthalmology

1. Chairman's Remarks—Dr. Carl McClelland, Detroit.
2. "Focal Infections in Cataract"—Dr. J. G. Huizinga, Holland.

   This paper is not based on laboratory experimentation, but on clinical observation over a period of more than forty years. It discusses the possible influence of focal infections of the head as etiologic factors in the cause of that comparatively rare type of cataract encountered in early mid-life but in many other respects similar to the simple senile type. It proposes a theory for the etiology of senile cataract.

   Discussion—
   1. Dr. Dodge, Battle Creek.
   2. Dr. John Wetzel, Lansing.
3. "Superficial Punctate Keratitis"—Dr. Alfred Dean, Grand Rapids.

   The past four years have brought financial losses, worry, insanity and suicide. Lack of employment has meant forced economy, resulting in nutritional deficiency; while prolonged mental strain has brought nerve exhaustion with defective assimilation responsible for a nutritional deficiency or avitaminosis reflected as a visible symptom, superficial punctate keratitis.

   Discussion—
   1. Wm. H. McGarvey, Jackson.
   2. C. W. Ellis, Lansing.
4. "Intra-ocular Foreign Bodies with Review of Eighty Cases"—Dr. Don Marshall, Ann Arbor.

   After considering briefly some of the recent literature on the management of intra-ocular foreign bodies, a concise analytical review of eighty cases is presented, raising questions concerning the urgency, and proper method, of extraction of intra-ocular foreign bodies, and the ultimate prognosis of such injuries.

   Discussion—
   1. Dr. H. L. Begle, Detroit.
   2. Dr. H. T. White, Flint.
5. "Operations on the Orbit"—Dr. W. S. Benedict, Mayo Clinic.

   Operations for tumor of the orbit are frequently followed by deformities unless tissue loss can be minimized or compensated. Conservative methods of surgical treatment of tumor, abscess and malformation are described. Reconstruction of the socket for prosthesis by marsupialization and by skin graft is described and illustrated by lantern slides.

   Discussion—
   1. Dr. M. M. Dewar, Grand Rapids.
   2. Dr. Albert S. Barr, Ann Arbor.
6. "The Management of Glaucoma"—Dr. F. Bruce Fralick, Ann Arbor.

   This paper deals largely with a comparison of results of the various methods used in dealing with glaucoma simplex at the University of Michigan during the past five years. A brief review of the anatomic changes is given and illustrated in order to demonstrate why some forms of therapy are doomed to failure at one time and not at others. The medical and surgical procedures used in obtaining the tabulated comparative results are described, as well as the method of selection of the form of therapy to be used in any particular case.

   Discussion—
   1. Dr. R. D. Sleight, Battle Creek.
   2. Dr. A. R. McKinney, Saginaw.

Round Table Discussion at noon—Dr. W. S. Benedict.

Questions should be handed to the secretary early for Dr. Benedict's consideration.

Second Session—Thursday, Sept. 14, 1933
9:15 A. M.

Otolaryngology

1. "Foreign Bodies in the Bronchus: Report of Four Cases"—Dr. Walter K. Slack, Saginaw.

   Four cases are reported. The first, a ball bearing in the bronchus of an eight-year-old girl. The remaining three cases are of aspirated peanuts, each giving a different history and symptoms, the duration of their presence in the bronchus varying from one to three weeks.

   Discussion—
   1. Dr. G. C. Kreutz, Detroit.
   2. Dr. H. L. Simpson, Detroit.
2. "Management of Chronic Sinus Disease"—Dr. Ferris Smith, Grand Rapids.

   Discussion—
   1. Dr. James E. Cranshore, Detroit.
   2. Dr. Jacob Wendel, Detroit.
3. "Studies in Applied Anatomy of the Cervical Region"—Dr. A. C. Furstenberg, Ann Arbor.

   Discussion—
   1. Dr. Milton Robb, Detroit.
   2. Dr. A. J. Cortopassi, Saginaw.
4. "Suppurative Labyrinthitis"—Dr. Neil Bentley, Detroit.

   Two cases are being reported, one an acute suppurating ear with the development of an acute suppurative labyrinthitis and beginning meningitis. The second case was an old chronic mastoid with sudden onset of acute labyrinthitis, which sent on to complete destruction of the labyrinth and beginning facial paralysis. A radical labyrinth operation was performed in both cases with complete recovery.

   Discussion—
   1. Dr. Emil Amberg, Detroit.
   2. Dr. Oliver McGullicuddy, Lansing.

Round Table Conference at noon—Dr. A. C. Furstenberg.

Please hand to the Secretary questions to be discussed.

Pediatrics

Chairman: CAMPBELL HARVEY, Pontiac.
Secretary: EDGAR E. MARTMER, Detroit.

First Session

Wednesday, September 13, 9:00 A. M.

1. "Petrositis (Infections of the Temporal Bone)"—Dr. W. S. Gonne, Detroit.
   Case reports and a discussion of methods of treatment with lantern slides and roentgenograms.
2. "Diagnosis of Bronchiectasis in Childhood"—Dr. C. K. Hasley, Detroit.
   An evaluation of the value of roentgenograms and lipiodal injections in the diagnosis of early bronchiectasis in childhood. Lantern slides and roentgenograms.
3. "Diphtheria"—Dr. D. W. Gudakunst, Detroit.
   A survey of the diphtheria situation as it exists today in comparison with ten years ago including a discussion of the value of the Schick test and failure of antitoxin in certain cases.
4. "Newer Methods of Treatment of Congenital Syphilis"—Dr. A. Woodburne, Grand Rapids.
   An evaluation and discussion of the recently introduced arsenicals for oral administration and a comparison of the results obtained with the more generally known and utilized methods of treating this disease.
5. Reserved for Ann Arbor.

Second Session

Thursday, September 14, 9:00 A. M.

1. "Halibut Liver Oil with Viosterol"—Dr. E. W. May, Detroit.
   A discussion and report of a series of premature infants treated with the above preparation.
2. Subject to be announced—Dr. Rockwell M. Kempton, Saginaw.
3. Subject to be announced—Dr. John Parsons, Ann Arbor.
4. "Current Conceptions of Blood Dyscrasies in Infancy"—Dr. T. B. Cooley, Detroit.
   A résumé of the recent work with blood.
5. "Calcium Metabolism"—Dr. A. E. Newberg, Ann Arbor.
   Dr. Newburgh will give a résumé of the recent advances in calcium metabolism.
6. "Physiology of the Gastro-intestinal Tract in Infancy and Childhood"—Dr. Wingate Todd, Cleveland, Ohio.

Dermatology and Syphilology

Chairman: G. H. BELOTE, Ann Arbor.
Secretary: A. R. WOODBURNE, Grand Rapids.

Wednesday, Sept. 13, 1933—9:15 A. M.

1. "Metaphen Dermatitis—A Report of Two Cases" Dr. G. H. Belote, Ann Arbor.
2. "Some Unusual and Interesting Lesions of the Oral Mucous Membrane"—Dr. A. R. Woodburne, Grand Rapids.
3. "Pseudosyphide"—Dr. P. O. Poth, Ann Arbor.
4. "A Discussion of the Diseases of the Instability Group"—Dr. Ruth Herrick, Grand Rapids.

Thursday, Sept. 14, 1933, 9:15 A. M.

Clinic: Presentation and Discussion of Cases.

Make a list of your needs and give your orders to the firms making commercial exhibits. Patronize them—they patronize you.

HOUSE OF DELEGATES

Speaker: Henry J. Pyle, M.D., Grand Rapids.
Vice-Speaker: C. E. Dutchess, M.D., Detroit.
Secretary: F. C. Warnshuis, M.D., Grand Rapids.

First Session

Monday, September 11, 1933, 2:00 P. M.

Ball Room—Pantlind Hotel

1. Call to Order.
2. Report of Credentials Committee.
3. Roll Call.
4. Speaker's Address.
5. President's Address.
6. President-Elect's Address.
7. Annual Report of Council.
8. Appointment of Reference Committees.
   (a) Council.
   (b) Society Affairs.
   (c) Miscellaneous Business.
   (d) Report of Committees
9. Report of Committee on Economics—W. H. Marshall, Chairman.
   This is a special order of business determined at the special meeting of July 12. Upon completion of this special order the House will proceed with the following order of business at hours to be determined at the close of each session.
10. Election of Nominating Committee.
    (a) To Nominate:
        1. One Delegate to A. M. A.
        2. Two Alternate Delegates to A. M. A.
        3. Place for Annual Meeting.
11. Committee Reports.
    1. Legislative.
    2. Civic and Industrial Relations.
    3. Woman's Auxiliary.
    4. Survey of Medical and Health Agencies.
    5. Radio Committee.
    6. Preventive Medicine.
    7. Delegates to A. M. A.
    8. Special Committees.
12. Resolutions and New Business.
13. Adjournment.

Second Session

Tuesday, September 12, 1933

1. Call to Order.
2. Roll Call.

2A. 10:00 A. M. Special Address: REV. FATHER ALPHONSE SCHWITALL, S.J., Dean of Medicine, St. Louis University, St. Louis, Mo.

[The Delegates will be privileged to hear this distinguished speaker. Doctors, hospital and health officials, and nurses, are urged to hear this address.]

3. Reference Committees.
   (a) Council
   (b) Miscellaneous Business
   (c) Society Affairs.
   (d) Reports of Committees.
4. Unfinished Business.
5. Resolutions and New Business.
6. Adjournment.

Third Session

1. Report of Credentials Committee.
2. Roll Call.
3. Reports of Reference Committees.
4. Elections:
   1. President-Elect.
   2. Delegate to A. M. A.
      L. J. Hirschman—Term Expiring.

3. Alternate A. M. A. Delegates.
   Carl F. Moll—Term Expiring.
   Henry E. Perry—Term Expiring.
4. Councilors.
   13th District—B. H. Van Leuvan—Term Expiring.
   14th District—J. D. Bruce—Term Expiring.
5. 1934 Meeting Place.
6. Speaker.
7. Vice-Speaker.
8. Unfinished Business.

DELEGATES AND ALTERNATES

Annual Meeting, Grand Rapids, Sept. 11-14, 1933*

Alpena County
E. L. FOLEY
H. J. Burkholder

Barry County
M. R. KINDE
Guy Keller

Bay-Arenac-Iosco
L. F. FOSTER
A. D. Allen

Berrien
W. C. ELLET
Edwin Vary

Branch

Calhoun
C. S. GORSLINE
A. T. HAFFORD
W. L. Godfrey
A. D. Sharp

Cass

Chippewa-Mackinac

Clinton
G. H. FRACE
D. W. Hart

Delta
JOHN W. TOWEY
Louis P. Groos

Dickinson-Iron

Eaton
A. G. SHEETS
K. Anderson

Genesee
FRANK REEDER
GEORGE CURRY
C. F. MOLL
H. Randall
Donald Wright
Max Burnell

Gogebic

Grand Traverse-Leelanau
E. B. MINOR
E. F. Sladek

Gratiot-Isabella-Clare
T. J. CARNEY
W. L. Harrigan

Hillsdale
A. E. MARTINDALE
C. T. Bower

Houghton
WM. T. KING
W. A. Manthei

Huron-Sanilac
W. D. HOLDSHIP
D. D. McNaughton

Ingham
L. G. CHRISTIAN
KARL BRUCKER
Fred Huntley
Ford DeVries

Ionia-Montcalm
W. W. NORRIS
C. H. Peabody

Jackson
PHILLIP RILEY
JAMES O'MEARA
C. S. Clarke
H. A. Brown

Kalamazoo
F. T. ANDREWS
L. V. ROGERS
N. L. GOODRICH
A. A. McNabb
Paul Schrier
John MacGregor

Kent
A. V. WENGER
G. H. SOUTHWICK
J. D. BROOK
CARL F. SNAPP
LEON E. SEVEY
A. M. Moll
E. N. Nesbitt
E. W. Schnoor
J. N. Holcomb
F. A. Votey

Lapeer
H. M. BEST
J. A. Spencer

Lenawee
E. C. RAABE
A. W. Chase

Livingston
R. S. ANDERSON
J. J. Hendren
R. S. Anderson

Luce
H. E. PERRY
E. H. Campbell

Macomb
J. N. SCHER
G. F. Moore

Manistee
A. A. McKAY
Stephen Fairbanks

Marquette-Alger
V. VANDEVENTER
R. A. Burke

Mason
L. W. SWITZER
Chas. Paukstis

Mecosta
G. H. YEO
Paul Kilmer

Menominee

Midland
CHARLES L. MacCALLUM
Arthur W. Newitt

Monroe
P. D. AMADON
D. C. Denman

Muskegon
F. W. GARBER, SR.
J. C. Bloom

Newaygo
A. C. TOMPSETT
H. R. Moore

Northern Michigan
FRED MAYNE
Guy Conkle

Oakland
C. T. EKELUND
R. H. BAKER
A. D. Riker
D. G. Castell

Oceana

Otsego-Montmorency, Crawford-Oscoda-Roscommon-Ogemaw
CLAUDE R. KEYPORT
Clarence G. Clippert

*Delegates in capitals, alternates in lower case.

Ontonagon
Ottawa
Saginaw
R. M. KEMPTON
G. HARRY FERGUSON
Donald Durman
Schoolcraft
A. R. TUCKER
Donald Ross
Shiawassee
I. W. GREENE
St. Clair
A. L. CALLERY
W. P. Derck
St. Joseph
R. A. SPRINGER
J. V. Blood
Tri-County
Tuscola
C. N. RACE
E. C. Swanson
Washtenaw
JOHN SUNDWALL
H. H. CUMMINGS
S. Donaldson
Geo. Muehlig
Wayne
H. W. YATES
H. W. PLAGGEMEYER
W. D. BARRETT
H. A. LUCE
R. M. McKEAN
A. W. BLAIN
E. C. BAUMGARTEN
A. P. BIDDLE
WM. J. STAPLETON, JR.
G. C. PENBERTHY
B. L. CONNELLY
E. D. SPALDING
J. L. CHESTER
L. J. CARIEPY
W. R. CLINTON
WM. S. REVENO
C. F. BRUNK
A. E. CATHERWOOD
L. T. HENDERSON
C. K. HASLEY
B. U. ESTABROOK
D. I. SUGAR
S. W. INSLEY
L. O. GEIB
D. P. FOSTER
C. K. Valade
F. C. Witter
C. E. Lemmon
L. W. Shaffer
J. C. Kenning
R. S. Goux
G. A. Wilson
J. B. Rieger
S. A. Flaherty
R. Lee Laird
C. E. Umphrey
H. W. Peirce
S. E. Gould
E. V. Beardslee
C. S. Ratigan
F. S. Perkin
V. L. Van Duzen
G. M. Livingston
J. H. Chance
G. L. Coan
W. H. Shipton
A. H. Bracken
R. C. Leacock
E. H. Engel
A. H. Whittaker

LEGISLATIVE COMMITTEE

The experiences of this committee in the course of its work through this unusual, uncertain, prolonged session of the Legislature would have supplied a Paul DeKruif or a Bernard Shaw not only with material for fascinating entertainment for their readers but for lessons in social, economic and political obligations, burdening the medical profession today. Difficulties for and the obstacles against good legislation must have become so thoroughly comprehended by the medical profession that it can effectively organize its great potential political power and ally itself with other professions and friendly groups awaiting alliance. This potential influence of the nearly six thousand doctors in Michigan, if harnessed and coördinated, could accomplish anything for the good of public health that might be desired. Because medical men have never harmonized politically and although individual doctors are held in high esteem, small groups have been able to interfere with and obstruct legislation requirements in medical education and public health standards.

Circumstances today create a challenge as never before and the medical profession must play a dominating part in Michigan's politics. It must organize the towns, counties and the state to impart to the public that knowledge which it can best give. It must take a hand in the selection of proper men for public office. It must know candidates and it must know those who are nominated.

The medical profession must so organize. The experiences of this 1933 session have clearly and undisputably shown the necessity. There must be a central directing office and a full time director.

This is not new thought of this committee. Many doctors have come to the committee and made similar suggestions. All or nearly all who have participated in our political difficulties have expressed something which would be the same or equivalent to this plan.

In this session there were approximately one thousand proposals introduced and of this number nearly one-third were passed and reached the governor. Of all subjects introduced nearly one-fourth are of especial or of slight interest to the medical profession. We have grouped the following bills which are of especial interest and have shown the disposition of each.

MALPRACTICE BILLS

Senate Bill No. 24, introduced by Senator Ray Durhan, Iron Mountain, amending Workmen's Compensation Act to allow employee to claim compensation without losing the right to sue for damages. Direct threat against the medical profession. Passed Senate. Reported out by House Labor Committee. Re-referred to House Judiciary Committee. Died in Committee last day of session.

House Bill No. 216, introduced by Mr. Earl L. Burhans, Paw Paw, permitting judgments in tort to be used on and renewed, indefinitely. Died in House Judiciary Committee.

TAXATION BILLS

House Bill No. 184, introduced by Mr. Tracey W. Southworth, Monroe, providing for a three per cent tax on gross incomes of professional people, and also three per cent tax on all sales. Passed House. Amended in Senate to eliminate income tax. Passed Legislature as a straight sales tax. Approved by Governor. (Enrolled Act. No. 173, P. A. No. 167.)

Senate Bill No. 100, introduced by Senator Henry C. Glasner, Charlotte, providing for taxation of net incomes and trust fund incomes. Defeated in Senate.

Senate Bill No. 184, introduced by Senator Claude B. Root, Greenville, providing a gross income tax on persons and corporations. Died in Committee on Taxation.

Senate Bill No. 27, introduced by Senator A. L. Moore of Pontiac, permitting payment of 1928, 1929, 1930 and 1931 taxes in ten annual installments, and cancelling all overdue taxes prior to 1928. Passed Legislature and approved by the Governor. (Act. No. 126, P. A. of 1933).

HEALING ARTS BILLS

House Bill No. 474, introduced by Mr. John P. Connors, Detroit, permitting Osteopaths unlimited practice of medicine and surgery, with no distinction to be made between physi-

cians and surgeons, M.D., and osteopaths. Vetoed by the Governor June 21st.

Senate Bill No. 106, introduced by Senator James T. Upjohn, Kalamazoo, prescribing educational qualifications of persons who wish to study for practice of the healing art, and creating a Board of Examiners thereof. Died in Senate Committee on Public Health.

House Bill No. 398, introduced by Rep. John G. Rulison, Lansing, making necessary amendments in the Medical Practice Act. Passed the House. Died in Senate Public Health Committee.

House Bill No. 389, introduced by Mr. Laverne Hatch, Horton, providing for the appointment of a Board of Chiropractic Examiners and for the licensing of applicants. Approved by the Governor, June 21. (Enrolled Act No. 131, P. A. No. 145.)

House Bill No. 66, introduced by Messrs. Hartman and Brown to repeal the appropriation for the Homeopathic Medical Department of the U. of M. Approved by the Governor. (Enrolled Act No. 3, P. A. No. 5, I. E.)

House Bill No. 441, introduced by Mr. T. Thomas Thatcher, Ravenna, to regulate the practice of optometry. Died in House Committee on Public Health.

House Bill No. 457, introduced by Mr. John Dykstra, Muskegon, to amend the law relative to optometrists. Died in House Committee on Public Health.

Senate Bill No. 144, introduced by Sen. Henry C. Glasner, Charlotte, to create a department of registration of professions. Died in Senate State Affairs Committee.

Senate Bill No. 195, introduced by Messrs. Doyle and Asselin, regulates hours for nurses on duty in hospital. Not passed by House.

Senate Bill No. 140, introduced by Senator Charles B. Asselin, Bay City, to make it a misdemeanor for a city, county or state nurse to diagnose a case or prescribe treatment or use her position to promote any physician or particular school of healing. Tabled in Senate May 26.

House Bill No. 513, introduced by Mr. D. G. Look, Lowell, to require pharmacists to take examinations or graduate from recognized school. Passed and approved by Governor. (Enrolled Act No. 121, P. A. No. 141.)

House Bill No. 531, introduced by Messrs. McInerney and Thatcher to prevent issuance of pharmacy license to persons selling groceries to raise standards of applicants for license. Not passed by Senate.

House Bill No. 579, introduced by Mr. James G. Frey, Battle Creek, permits Chiropodists to treat ailments of human leg and foot medically, surgically, mechanically or by physiotherapy. Permits use of "Dr." if word chiropodist follows name. Not passed by Senate.

House Bill No. 170. New dental bill repealing old law. Provides for board of seven for seven year term; requires 30 hours preliminary college and 60 hours in dental school, annual registration and prohibits practicing or advertising under firm or trade name or of corporation or association. Passed legislature and approved by Governor. (Enrolled Act No. 183, P. A. No. 235.)

STATE CARE AND INDIGENTS

House Bill No. 16, introduced by Messrs. Hartman and Brown to abolish the Crippled Children's Commission and transfer its duties to the Superintendent of Public Instructions. Died in House Ways and Means Committee.

House Bill No. 173, introduced by Messrs. Hartman and Brown, giving more powers to the Crippled Children's Commission. Substituted on April 10 to include afflicted children. Died in House Committee on Ways and Means.

House Bill No. 171, introduced by Mr. Fred E. Watkins, Pontiac, allowing afflicted children to receive medical and surgical care in approved hospitals other than the University Hospital, but then at county expense, traveling expense partly borne by county, administration by Crippled Children's Commission. Provides that a fee scheduled for doctor be drawn. Approved by the Governor July 10. (Enrolled Act No. 210, P. A. No. 248. I. E.)

House Bill No. 354, introduced by Mr. M. Clyde Stout of Ionia, providing that expenses of conveying afflicted children to and from University Hospital shall be allowed by the Supervisors of the County from which such children were sent. Died in House Public Health Committee.

House Bill No. 409, introduced by Mr. Lester T. Barber, Edmore, providing that "legally qualified physicians" shall furnish the history on an afflicted child. Died in House Public Health Committee.

House Bill No. 410, introduced by Mr. Lester T. Barber, Edmore, providing that "legally qualified physicians" shall furnish the history on an afflicted adult. Died in House Public Health Committee.

House Bill No. 404, introduced by Mr. Vernon J. Brown, Mason, reducing the fee for medical examinations of afflicted adults from $5.00 to $3.00. Passed House. Killed in Senate by indefinite postponement.

House Bill No. 319, introduced by Rep. Charles M. Myers, Dowagiac, providing that the family physician be the examining physician of afflicted adults. Died in the House Public Health Committee.

House Bill No. 583, introduced by Mr. J. C. Coumans, Bay City, providing that other than the University Hospital, and other physicians than those of the University Hospital be utilized for the care and treatment of afflicted adults. Approved by the Governor July 6. (Enrolled Act No. 182, P. A. No. 222.)

House Bill No. 616, introduced by Mr. Edward J. Walsh of Detroit, providing that Judges of Probate may order afflicted adults sent to city or county hospitals. Died in House Public Health Committee.

House Bill No. 318, introduced by Rep. Charles M. Myers, Dowagiac, providing that the family physician be one of the two examining physicians in insane and feeble minded cases. Died in House Public Health Committee.

House Bill No. 405, introduced by Mr. Vernon J. Brown, Mason, changing the fee for medical examination of insane persons from "five dollars" to "not less than three dollars," except in counties with population over 250,000. Approved by the Governor. (Enrolled Act No. 75, P. A. No. 85.)

Senate Bill No. 138, introduced by Senator W. F. Doyle, Menominee, providing that epileptic and feeble minded persons may be committed to private homes until provisions in proper state institution is made, the state reimbursing the county for cost of maintenance. Passed Senate. Died in House Committee on Towns and Counties.

House Bill No. 135, introduced by Mr. M. Clyde Stout, Ionia, limited the funeral expenses of deceased persons to $125.00 when there is not sufficient estate to cover all debts. Expenses of last illness must be paid second in order. Not passed.

House Bill No. 458, introduced by Mr. J. P. Connors, Detroit, to make an appropriation for Children's Fund of Michigan for research on dental caries. Killed in Home Committee of Ways and Means.

Senate Bill No. 213, introduced by Senator James T. Upjohn, Kalamazoo, to provide for sterilization of feeble-minded, insane persons, moral degenerates and sexual perverts. Died in Senate Committee on Public Health.

WORKMEN'S COMPENSATION

House Bill No. 153, introduced by Mr. Joseph C. Roosevelt, Detroit. When employee wins appeal from decision of Board, he can charge employer or insurer for his attorney and physician's fees. Died in House Committee on Labor.

House Bill No. 276, introduced by Rep. H. E. Perry, Newberry, reduces compensation from $18.00 to $12.00 with minimum from $7.00 to $6.00. Not passed.

House Bill No. 402, introduced by Mr. H. L. Nichols, Jackson, changes method of computing average weekly wages from "six times" daily wage to the "daily wage multiplied by the number of days per week employee is then actually working." Died in Committee on Labor.

Senate Bill No. 147, introduced by Mr. James A. Murphy, Detroit, prescribes provisions to cover disability or death due to occupational diseases according to list of 16 causes. Died in Senate Committee on Labor.

Senate Bill No. 156, introduced by Mr. James A. Murphy, Detroit, prohibits attending physician to testify at hearings except by waiver of employee. Provides for re-hearings of final awards within 60 days. Defeated in Senate June 6.

House Bill No. 622, introduced by Mr. William C. Buckley, Detroit, proposes to increase medical care from 90 to 180 days. Not passed Senate.

OCCUPATIONAL DISEASE BILLS

House Bill No. 140, introduced by Mr. Wm. C. Birk at the request of Mr. Alvin L. Rummel of Ironwood, including any "disability" arising out of or in the course of employment from any disease or injury proximately caused by employment. Died in House Committee on Labor.

House Bill No. 214, introduced by Mr. Wm. G. Buckley of Detroit, including such occupational disease or infection as arises out of and is incidental to the employment. Died in House Committee on Labor.

Senate Bill No. 147, introduced by Senator James A. Murphy, Detroit, covering disability or death due to occupational diseases re-referred to Senate Committee on Labor.

OLD AGE PENSIONS

Senate Bill No. 2, introduced by Senator Ray Durhan, Iron Mountain, creating an Old Age Pension. Died in Senate Committee on State Affairs.

House Bill No. 100, introduced by Mr. Michael J. Grajewski, Jr., of Detroit, providing for Old Age Pensions payable by the state. Approved by the Governor July 7. (Enrolled Act No. 175, P. A. No. 237.)

House Bill No. 163, introduced by Messrs. Cameron and Jewell, providing for Old Age Pensions. Died in House Committee on State Affairs.

House Bill No. 521, introduced by Mr. Wm. G. Buckley, providing for Old Age Pensions. Died in House Committee on State Affairs.

House Bill No. 599, introduced by Mr. George L. Teachout of Flint, providing for Old Age Pensions. Died in House Committee on State Affairs.

House Bill No. 638, introduced by Mr. Jos. S. Brzostowski of Detroit, providing for Old Age Pensions. Died in House Committee on State Affairs.

UNEMPLOYMENT INSURANCE

Senate Bill No. 167, introduced by Senator Leo G. Karwick of Hamtramck, establishing unemployment insurance and commission to regulate same. Died in Senate Committee on Judiciaries.

House Bill No. 502, introduced by Mr. Wm. C. Buckley,

providing unemployment insurance payable by state. Died in House Committee on Labor.

LIQUOR

House Bill No. 277, introduced by Mr. Joseph C. Murphy. Amends prohibition law to permit physician or dentist to prescribe amounts of liquor equal to that allowed by any act of congress. Died in House Committee on Liquor Traffic.

House Bill No. 300, introduced by Mr. Willis E. Cuthbertson, Flint. Repeals state prohibition law. Died in House Committee on Liquor Traffic.

House Bill No. 200, introduced by Mr. E. G. Nagel, Detroit. Raises amount of liquor prescribable by physicians and dentists from 8 to 16 ounces pending repeal of 18th amendment. Passed and approved by Governor. (Enrolled Act No. 141, P. A. No. 150.)

House Bill No. 557, introduced by Mr. John Dykstra. Muskegon. To repeal law permitting physicians to prescribe liquor to patients. Died in House Committee on Liquor Traffic.

Senate Bill No. 204, introduced by Senator A. J. Wilkowski, Detroit, removing restrictions on prescribing liquor for medical purposes to conform with Federal Law. Died in Senate Committee on Prohibition.

Senate Bill No. 242, introduced by Senator Ray C. Derhan, Iron Mountain, to change prescribable alcoholic dosage from 8 ounces to "amount necessary for patient's medical needs." Referred to Senate Committee on Prohibition.

VITAL STATISTICS

House Bill No. 304, introduced by Mr. H. L. Nichols, Jackson. Birth or death certificates are prima facie evidence of facts contained therein. Not passed.

House Bill No. 343, introduced by Messrs. Morley and Myers. Repeals five-day requirement for license to marry. Not passed.

Senate Bill No. 160, introduced by Senator John W. Ried, Highland Park. Legalizing pre-marital births and recording same on birth certificates. Passed and approved by Governor. (Enrolled Act No. 51, P. A. No. 172.)

House Bill No. 178, introduced by Rep. E. F. Fisher, Dearborn, The birth certificates of a legally adopted child shall bear the names of the new parents and shall not disclose illegitimacy. Passed and approved by the Governor. (Enrolled Act No. 98, P. A. No. 105.)

CARE OF THE TUBERCULOUS

Senate Bill No. 42, introduced by Senator Leon D. Case, Watervliet, reduces compensation paid to counties by the State for treatment and care of indigent tuberculous patients from one dollar to seventy-five cents per diem. Passed and approved by the Governor July 6. (Enrolled Act No. 74, P. A. 215.)

Senate Bill No. 44, introduced by Senator Leon D. Case, Watervliet, provides for appropriation of $1,600,000.00 from the general fund of the State for partial payment of state liability for expense in care and treatment of indigent tuberculous patients in Tuberculosis Sanitariums. Passed and approved by the Governor March 11. (P. A. No. 27.)

Senate Bill No. 84, introduced by Senator C. A. Campbell, Indian River, amends malt tax law to require chain store organizations to have license for each store to sell malt products. Passed and approved by Governor. (Enrolled Act No. 54, P. A. 175.)

Senate Bill No. 99, introduced by Senator Ray Derhan, Iron Mountain. New malt tax and to replace malt tax law of 1931. Passed but vetoed by Governor.

House Bill No. 35, introduced by Messrs. Hartman and Brown. Disposition of malt tax moneys. Passed and approved by Governor. (Enrolled Act No. 140, P. A. No. 157.)

House Bill No. 106, introduced by Mr. James W. Helme, Adrian. Repeals provision for construction and maintenance of Northern Michigan Tuberculosis Sanitarium. Died in House Committee on State Affairs.

House Bill No. 110, introduced by Mr. William C. Birk, Baraga. Repeals malt tax law 1931. Died in Committee on Public Health.

House Bill No. 435, introduced by Mr. M. Clyde Stout, Ionia. To make appropriations for Michigan State Sanitarium. Passed and approved by Governor. (Enrolled Act No. 128, P. A. No. 106.)

House Bill No. 469, introduced by Mr. H. L. Nichols, Jackson, to amend malt tax law reducing registration fee from $25.00 to $10.00 and requiring each store separate registration "even though the same may be a unit of a corporation or holding company." Not passed by Senate.

MISCELLANEOUS

House Bill No. 191, introduced by Messrs. Hartman and Brown. Psychopathic Hospital, Ann Arbor, to be administered by Board of Regents instead of present board of trustees. Not passed.

House Bill No. 265, introduced by Mr. D. D. Tibbits, Charlevoix, declares ragweed and goldenrod among noxious weeds to be cut down, pulled out and destroyed by land owner. Died in House Committee on Agriculture.

House Bill No. 268, introduced by Mr. Earl L. Burhans, Paw Paw, provides that in counties of less than 50,000 population the two coroners shall be appointed for two year term by the State Health Commissioner. Not passed.

House Bill No. 509, introduced by Mr. M. Clyde Stout, Ionia, Appropriations for various State boards. Passed and approved by Governor. (Enrolled Act No. 150, P. A. No. 188.)

House Bill No. 511, introduced by Mr. M. J. Grajewski, Jr., Detroit, authorizing autopsies on unclaimed dead bodies. Not passed by Senate.

House Bill No. 606, introduced by Messrs. Bischoff and Baginski, to prohibit compulsory life, health or accident insurance of employee. Died in House Committee on Labor.

House Bill No. 656, introduced by Rep. John G. Rulison, Lansing, proposes to accord hospitals to treat persons injured through faults of others, liens on all judgments, claims, etc., accruing to injured person by reason of the injury. Not passed in Senate.

House Bill No. 580, introduced by Mr. D. G. Look, Lowell. Eliminates provision to include in preparations containing habit forming drugs, other drugs to prevent use of preparation by addicts. Not passed by Senate.

House Bill No. 620, introduced by Messrs. Schneider and Buckley. "Uniform Narcotic Drug Act." Died in House Committee on Judiciary.

House Bill No. 283, introduced by Messrs. Connors and Kirkwood. Regulations of Barbers and Hair cutters. Passed and approved by Governor. (Enrolled Act No. 94, P. A. No. 106.)

The Committee acknowledges the valued aid of many county societies and of many individuals in the profession who were ready at all times to respond, to contribute and to participate. Many lay friends and politically powerful individuals contributed liberally of time and in a number of instances at financial cost to themselves to aid us in our interest and in the interest of the commonwealth. Representatives of large and important businesses became interested in some of our problems and aided immeasurably.

The Wayne County Medical Society arranged to have its Executive Secretary, Mr. William J. Burns, present in Lansing during legislative days. Known to all as Bill Burns, the able and affable executive secretary labored effectively day and night on the problems confronting the medical profession.

Respectfully submited,

CARL F. MOLL
WM. C. MCCUTCHEON
GROVER C. PENBERTHY
WM. A. HYLAND
EARL I. CARR, *Chairman*

August 9, 1933.

CIVIC AND INDUSTRIAL RELATIONS COMMITTEE

The chief activity of the Civic and Industrial Relations Committee this year has consisted of drafting a Professional Lien Law.

Conforming to the Committee's recommendation of last year and the request of the Executive Committee of the Council, the chairman made a study of the indications for a Professional Lien Law in Michigan that would cover the needs of physicians, dentists, nurses and hospitals. With the advice and assistance of the Bureau of Legislation of the American Medical Association, a proposed bill was prepared.

The chairman of the Civic and Industrial Relations Committee met with the Legislative Committee in Lansing on March 1, 1933. and the proposed bill was discussed. It was agreed that the bill in its final form should be submitted to the Legislative Committee for introduction through the proper channels into the State Legislature. Unfortunately, conditions arose that made it inadvisable to introduce the bill because of the effect that it would have upon other pending medical legislation. An effort was made on the part of another group to introduce a similar bill, but one not including the medical profession, nurses or dentists. Fortunately, this bill died in committee and did not come before the Legislature.

Your Committee is optimistic and believes that

there is need for a Professional Lien Law in Michigan and recommends that such a bill be introduced into the Legislature at a later session.

Respectfully submitted,
HARRISON S. COLLISI, M.D., *Chairman.*

RADIO COMMITTEE

The Michigan State Medical Society.
Gentlemen:

Under instructions of the House of Delegates, the State Secretary is directed to secure and publish in the JOURNAL, before each annual meeting, the annual reports of the Society's standing committees. Accordingly, as chairman of the Radio Committee, I submit the following report.

The report is made up of the various reports of County Societies who were doing radio broadcasting. It was thought in this manner the Council, House of Delegates and members of the Society could more easily evaluate the work.

Sincerely yours,
WILLIAM J. STAPLETON, JR., M.D.,
Chairman.

KENT COUNTY

Dr. William J. Stapleton,
Detroit, Michigan.
Dear Doctor Stapleton:

We have done no broadcasting this year. It was brought to our attention that the State Society was broadcasting, and with the work the American Association is doing, our committee felt that we should keep off the air.

Sincerely yours,
GEORGE L. BOND, M.D.

BERRIEN COUNTY

My dear Doctor Stapleton:

We have not been broadcasting for the past year for the reason that our local station, WEMC, of Berrien Springs has been discontinued.

I understand that it was sold to a Kalamazoo syndicate and have never heard it on the air since, so do not know whether it is in existence or not.

There are no other broadcasting stations in our county so we have of necessity had to drop such work.

Sincerely,
W. C. ELLET, M.D.

BAY COUNTY

Dear Dr. Stapleton:

Fifteen of our members presented 25 broadcasts over WBCM from October 1, 1932, to March 21, 1933. On the latter date, we were forced to give up our time when the local station went off the Columbia chain.

The announcer gave the following introduction to all our broadcasts:

"You will now hear a health talk, sponsored by the Bay County Medical Society and given by one of its members, Dr. ....."

In closing he said, "You have just listened to a health talk, sponsored by the Bay County Medical Society and given by Dr. ....."

The following list gives the names of our members and the number of times they broadcasted:

Dr. L. F. Foster	3	Dr. D. Mosier	1
Dr. W. R. Ballard	1	Dr. Jos. Grosjean	2
Dr. R. H. Criswell	2	Dr. H. Lawrence	2
Dr. R. C. Perkins	2	Dr. E. S. Huckins	1
Dr. A. L. Ziliak	3	Dr. E. C. Miller	1
Dr. A. D. Allen	1	Dr. C. A. Groomes	1
Dr. N. R. Moore	2	Dr. J. McLean	1
Dr. George Brown	2		

Fraternally yours,
L. FERNALD FOSTER, M.D.

JACKSON COUNTY

Dear Dr. Stapleton:

As you requested, I am mailing you a list of the radio talks which have been sponsored by the Jackson Medical Society since my last report.

We broadcast each Tuesday morning over our local station WIBM for a fifteen minute period begining at 10:45. We have never announced the name of the speaker merely stating that a member of the Jackson County Medical Society would speak, and announce the subject.

I gave a rather detailed report of our experiences with radio broadcasting at the annual Conference of the County Secretaries held in Grand Rapids last March. This report was published in the State JOURNAL and I believe you will find it will answer any questions you may have in regard to our local work.

Yours truly,
R. H. ALTER, M.D.

(Your chairman recommends a reading of Dr. Alter's articles to all who are interested in radio as effects the medical profession.)

RADIO PROGRAMS BY JACKSON MEDICAL SOCIETY

Oct. 25	Vincent's Infection. Dr. Cochrane.
Nov. 1	What to do When a Bone is Broken. Dr. C. Corley.
Nov. 8	The Reason for Periodic Health Examinations. Dr. Enders.
Nov. 15	Care of Normal Skin. Dr. Crowley.
Nov. 22	A Doctor Looks at Cleanliness and Health. Dr. Hardie.
Nov. 29	Hernia. Dr. Harris.
Dec. 6	Holding the Line. Dr. Hanna.
Dec. 13	Communicable Disease in the Home. Dr. Hurley.
Dec. 20	Obesity Due to Glandular Disturbance. Dr. Jones.
Dec. 27	A Change of Climate. Dr. Kunder.
Jan. 3	Radium Fakes. Dr. Kugler.
Jan. 10	That Tired Feeling. Dr. Lake.
Jan. 17	Rheumatism. Dr. Thayer.
Jan. 24	Heart. Dr. Lewis.
Jan. 31	Influenza. Dr. Leonard.
Feb. 7	Ear and Its Diseases. Dr. McGarvey.
Feb. 14	Goiter. Dr. Ludwick.
Feb. 21	Pneumonia. Dr. Meads.
Feb. 28	Uses and Abuses of Cathartics. Dr. Newton.
Mar. 7	Cancer and Women's Clubs. Dr. O'Meara.
Mar. 14	Prenatal Care. Dr. Peterson.
Mar. 21	Electrical Hazards in the Home. Dr. F. E. Pray.
Mar. 28	Contagious Disease of Childhood. Dr. G. R. Pray.
Apr. 4	Vermiform Appendix. Dr. Ransom.
Apr. 11	Headaches. Dr. Riley.
Apr. 18	Posture. Dr. Schmidt.
Apr. 25	Facts and Figures. Dr. Schaeffer.
May 2	Epidemic Influenza. Dr. E. C. Taylor.
May 9	Dialogue on Tuberculosis. Dr. VanSchoick.
May 16	Unwashed Hands. Dr. Chabut.

INGHAM COUNTY

Dear Doctor:

The Medical Society of Ingham County participated in the Health Education Program of the Michigan State Medical Society by giving a series of talks over radio station WKAR, Michigan State College, East Lansing.

There were eighteen talks given from January 12, 1933, to May 25, 1933, inclusive. Due to spring vacation at the Medical State College, there was no talk on March 30. On April 20 the Medical Society of Ingham County gave an afternoon clinic and the talk was not given on that afternoon, as all doctors wished to attend the clinic.

The following are the names of the doctors giving talks, title of subject, and date on which talks were given:

Jan. 12	Contagious Diseases. Dr. Russell Finch.
Jan. 19	The Periodic Health Examination. Dr. L. C. Towne.
Jan. 26	The Children are Cross. Dr. L. C. Hart.
Feb. 2	To Keep Our Eyes Well. Dr. M. C. Loree.
Feb. 9	Proper Prenatal Care. Dr. H. W. Wiley.
Feb. 16	Hay Fever. Dr. R. E. Goldner.
Feb. 23	Asthma. Dr. T. P. Vander Zalm.
Mar. 2	Diabetes. Dr. T. I. Bauer.
Mar. 9	Nervousness. Dr. C. W. Bradford.
Mar. 16	Animal Parasites in Man. Dr. L. C. Ludlum.
Mar. 23	Hygiene of the Skin. Dr. W. J. Cameron.
Apr. 6	Headache. Dr. R. A. Alton.
Apr. 13	The X-ray in Medicine. Dr. C. S. Davenport.
Apr. 27	Infections of the Nose and Throat. Dr. J. K. Heckert.
May 4	Dietary Fads and Fancies. Dr. Robert Phillips.
May 11	The Hospital; Today and Tomorrow. Dr. O. H. Bruegal.
May 18	Have You a Family Doctor? Dr. R. Kalmbach.
May 28	Early Signs and Recognition of Cancer. Dr. L. H. Darling.

These talks were put on as part of the educational program of the Michigan State College and were broadcast over their radio station, WKAR, every Thursday afternoon from 2:10 to 2:20.

There was some response to the programs by the listeners, but not as great as in previous years. The program director of station WKAR says that this is probably due to the fact that people do not write in to the radio stations now as they used to do.

The members of the Society coöperated splendidly when called upon to give the talks.

It is to be regretted that a more satisfactory hour can not be obtained when more people can be reached by these programs. I believe that if a time during the noon hour could be obtained that a much better response would be had and more people would hear the programs.

All in all, I believe the program for the year 1933 was successful.

At Station WKAR, Michigan State College, the doctor presenting the talks is announced by name. It is the policy of this station that all speakers' names are announced.

In Jackson the doctors' names are not announced, because the station management interprets it as individual advertising.

The speaker is announced as a member of the Jackson County Medical Society.

R. J. HIMMELBERGER, M.D.,
Ingham County Chairman
MILTON SHAW, M.D.,
District Chairman
J. EARL MCINTYRE, M.D.,
Councilor, Second District,
Michigan State Medical Society.

Dr. Fred Cole is chairman of the Radio Division of the Public Education Committee of the Wayne County Medical Society and I submit his report in full as showing the work done by the members of the Wayne County Medical Society in Detroit and Wayne County.

WAYNE COUNTY

Dear Dr. Stapleton:

I wish to summarize for you what has been accomplished by the Radio Section of the Public Education Committee.

The first talk over WWJ was given October 1, 1931. Since that time there has been sixty-nine Wayne County broadcasts upon a variety of subjects, most of which have to do with medical problems of general interest. The first talk over CKOK was given January 7, 1933, and there has been nineteen since that time. I have not given you the titles of these talks because of the fact that the secretary of Wayne County has the subjects on file and most all of the talks have been filed away in case we wish to have them repeated or given out to other county societies if requested.

This committee has tried to do two things; first, distribute the talks over the whole Society and to have them of general interest. We have several times through the BULLETIN called the Society's attention to the fact that any one interested would be given an opportunity to speak, also emphasizing the fact that the talk was the important thing and not the speaker. I personally feel that it would be a great backward step to do away with our radio program, especially as it is free, is educational for the public, and keeps the Wayne County Medical Society in the foreground as the important medical unit.

Sincerely yours,
FRED H. COLE.
Chairman of the Radio Section.

Dear Dr. Stapleton:

As Chairman of the Radio Section I am making you the following report. On WWJ and CKLW we have had the following talks:

Station WWJ—1931

Oct. 19	Common Colds. Dr. John Watkins.
Oct. 26	Physical Culture Fads. Dr. F. C. Musser.
Nov. 2	The Eye. Dr. Ralph Pino.
Nov. 9	Reducing Fads. Dr. C. J. Marinus.
Nov. 16	Urology. Dr. Wm. Keane.
Nov. 23	Are We All a Little Crazy? Dr. Dave Clark.
Nov. 30	Skin. Dr. R. Wollenberg.
Dec. 7	The Ear. Dr. W. Warren.
Dec. 21	Diphtheria. Dr. Franklin Top.
Dec. 28	Constipation. Dr. Stewart Wilson.

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Jan. 19	Truth and Fiction About Blood Pressure. Dr. Hugo Freund.
Jan. 26	Why a Medical Society? Mr. Wm. J. Burns.
Feb. 9	Heart Burden and Heart Consciousness. Dr. A. S. DeWitt.
Feb. 16	Relation of the Hospital to the Community. Dr. Stewart Hamilton.
Feb. 23	The Question of Indoor Climate in Relation to Respiratory Diseases. Dr. Lee Simpson.
Mar. 22	T. B. Week.
Apr. 5	T. B. Week.
Apr. 19	Nervousness: Everyday Problems. Dr. Martin Hoffman.
May 3	Our Daily Question Box. Mr. Wm. J. Burns.
May 17	Indigestion. Dr. Douglas Donald.
June 14	Growth and Care of the Baby. Dr. Milo Brady.
June 21	Romance of Anesthesia. Dr. Wm. Fowler.
June 28	Pseudo-medical Superstition. Dr. Dan Foster.
July 12	The Periodic Health Examination. Dr. L. O. Geib.
July 19	The Summer Camp for Diabetic Children. Dr. Franklin Peck.
July 26	What Everyone Should Know About the Eyes. Dr. Ben Glowacki.
Aug. 2	What Everyone Should Know About Appendicitis. Dr. Claire Vale.
Aug. 16	Obesity. Dr. Wm. Stapleton.
Aug. 23	The Significance of Pain in the Abdomen. Dr. H. W. Yates.
Aug. 30	Periodic Health Examination. Dr. Bruce Lockwood.
Sept. 6	Sleep. Dr. Clyde Chase.
Sept. 13	What the Laymen Should Know About Cancer. Dr. A. W. Blain.
Sept. 27	The Deafened. Dr. Emil Amberg.
Oct. 4	How Can I Know I Have Ear Disease? Dr. Walter J. Wilson.
Oct. 11	Facts and Fiction Concerning Appendicitis. Dr. Wm. J. Cassidy.
Oct. 18	How We Hear and How to Keep Our Hearing. Dr. Howard Pierce.
Oct. 25	Modern Surgery. Dr. W. A. Chipman.
Nov. 1	Facial Plastic Surgery: Its Possibilities and Its Dangers. Dr. Claire Straith.
Nov. 8	Varicose Veins. Dr. Miln C. Harvey.
Nov. 15	Childhood Fever. Dr. H. C. Walser.
Nov. 22	Some Facts About Moles. Dr. J. A. Hookey.
Nov. 29	The Vitamins. Dr. L. L. Newfield.
Dec. 6	Superfluous Hair and What to Do About It. Dr. Claude Behn.
Dec. 13	Recurrent Coughs in Children. Dr. H. S. Berman.
Dec. 20	Facts Concerning the Nose. Dr. Ray W. Hughes.
Dec. 27	Liver Disease. Dr. S. G. Meyers.

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Jan. 3	What Everyone Should Know About Cancerous Skin Changes. Dr. C. K. Hasley.
Jan. 10	Rheumatism. Dr. J. L. Chester.
Jan. 17	Foreign Bodies in the Air and Food Passages. Dr. W. A. Hudson.
Jan. 24	Eczema in Infants. Dr. W. C. C. Cole.
Jan. 31	Common Causes of Anemia. Dr. P. L. Ledwidge.
Feb. 7	Relation of Overweight to Disease. Dr. S. S. Altshuler.
Feb. 14	Dietary Facts and Fads. Dr. Frederick Sperry.
Feb. 21	The Heart and How It Works. Dr. E. D. Spalding.
Feb. 28	Blood Tests. Dr. Edward Robbins.
Mar. 7	Chronic Fatigue. Dr. H. V. Dwyer.
Mar. 14	Tuberculosis. Dr. Richard H. Morgan.
Mar. 21	Pimples (Acne)—Causes and Treatments. Dr. Loren W. Shaffer.
Mar. 28	Keeping Fit. Dr. A. R. Hackett.
Apr. 11	What to do Before the Doctor Arrives. Dr. Earl Lutz.
Apr. 18	The Art of Medicine. Dr. Wm. Woodworth.
Apr. 25	Having a Baby. Dr. Harry Kirschbaum.
May 2	New Methods in the Diagnosis of Tuberculosis. Dr. Bruce Lockwood.
May 9	Summer Camps in Tuberculosis Prevention. Dr. Burt Shurley.
May 16	Where Is the Other Case? Dr. A. M. Wehenkel.
May 23	Do Young Children Have Tuberculosis? Dr. J. R. Rupp.
May 30	The Hazard of Carbon Monoxide. Dr. Carl Schulte.

Station CKLW—1933

Jan. 7	Helping Public Health. Dr. Wm. Stapleton.
Jan. 14	Ringworm. Dr. R. C. Jamieson.
Jan. 21	Colds and the Modern Building. Dr. H. Lee Simpson.
Jan. 28	Present Status of Diabetes. Dr. Frank S. Perkin.
Feb. 4	Facts Concerning Goiter. Dr. R. W. Parr.
Feb. 11	Modern Obstetrics. Dr. L. E. Daniels.
Feb. 18	Practical Infant Care. Dr. Harold Clark.
Feb. 25	Hospital Cost and Care. Dr. E. T. Olsen.
Mar. 4	Earache and Running Ears. Dr. Neil Bentley.
Mar. 11	Simple Questions and Answers about Cancer. Dr. Harry Saltzstein.
Mar. 18	Ulcer of the Stomach. Dr. Edward Dowdle.
Mar. 25	Facts and Fancies on Heart Pains. Dr. Robert Berman.
Apr. 1	Acute Appendicitis. Dr. Louis Hromadko.
Apr. 8	Proper Care of Your Eyes. Dr. Leo. J. Croll.
Apr. 22	More About the Importance and Significance of the Periodic Health Examination. Dr. Harold W. Carlson.
Apr. 29	The Tuberculosis Case Finding Program. Dr. Howard Pierce.
May 6	Do Young Children Have Tuberculosis? Dr. W. C. C. Cole.
May 13	New Methods in the Diagnosis of Tuberculosis. Dr. E. S. Bullock.
May 20	Importance of X-ray in the Diagnosis of Tuberculosis. Dr. E. R. Witwer.
May 27	Eyesight as a Factor in the Mental and Physical cal Development of the Child. Dr. Arthur P. Wilkinson.

I want to take this opportunity to tell you that these radio stations have coöperated with us in every possible way. I feel that the Wayne County Medical Society has been fortunate to have this radio time given them. I am sure that we all realize that with few exceptions the members of the Wayne County Medical Society who have spoken over these stations have coöperated with our committee in having their talks properly prepared and of general interest.

I recently received a call from WZYX, who desire that we give them a period. Whether we will be able to carry three stations or not is a matter for the Committee to decide.

I am of the opinion that this method of educating the public along the same medical lines should be continued. The American Medical Society and different county societies in other large cities are doing this work and find it of value to the public and also to the society.

Sincerely yours,
FRED H. COLE,
Chairman of the Radio Section.

DETROIT

The Detroit Dairy and Food Council gave a series of twelve radio talks over Station WWJ under the title, "The Town Crier." The speakers were Dr. Henry Vaughn, Health

Commissioner; Dr. Archibold C. Thompson, Detroit District Dental Society, and Dr. William J. Stapleton, Jr., of the Wayne County Medical Society. Estimated weekly audiences were 250,000.

Dr. H. Vaughn:
Is Health Important?
Small Food Allowance.
Building Health Reserve.
Work of the Health Department.

Dr. A. C. Thompson:
Grown Children's Teeth.
Diet for Children's Teeth.
"Crooked Teeth" and their Treatment.
Pyorrhea.

Dr. Wm. J. Stapleton, Jr.:
The Control of One's Diet.
Your Lunch.
Preserving the Characteristics of Youth.
How Food Eccentricities Effect Your Popularity With Your Family.

RADIO BROADCASTING

"Principles Governing Contact of Physicians with the Public through the Press, Lecture Platform, Lay Periodicals and Radio." This is the title of a pamphlet prepared by the New York Academy of New York.

"The present tendencies in social and economic life have made it desirable that the medical profession, both as an aggregate body and through its individual members, should become more articulate in its relation to the public."

"Public Health Education differs from publicity and propaganda by the nature of its content." A statement, for example, that measles is a much neglected and dangerous disease made by Dr. Jones may serve as a typical example of a public health education message.

"Such a statement should not give special prominence to its maker. On the other hand, the statement is given impressiveness and authoritativeness when emanating from a representative physician or from an official medical body. Such a physician speaks not for himself but for the profession; he serves merely as a mouthpiece which expresses a fact universally agreed upon by physicians."

Radio broadcasting presents a number of singular problems which need individual consideration—"Anonymity in the radio is, therefore, incongruous. A physician making an address on the radio must, of necessity, be introduced by name. More than that, to establish his right to speak, his standing or connections, educational or associational, must be given. Any of those requirements can be fulfilled without violence to good taste or ethical proceudre."

The above is of interest because of the objections raised by some doctors against the use of names in radio talks. Your chairman has been in touch with the American Medical Association and various other state societies. In Illinois, where, I am informed, over five hundred radio talks were given last year, the doctor's name is always used. In Toledo, the policy is to use the doctor's name.

In Detroit we have always used the physician's name. I have personally talked with many and no one has ever had a patient come as a result of that particular talk. The American Medical Association sees no objection to the use of the doctor's name. They state it is a matter for the local society to decide. For those who are interested, we suggest sending to the New York Academy of Medicine, 2 East 103rd Street, New York City, for two pamphlets. One used as a heading for this note and the other entitled "On the Air," prepared by the Medical Information Bureau of the New York Academy of Medicine.

There is an interesting discussion entitled "Rating the Radio," by R. G. Leland, M.D., American Medical Association, March, 1931.

CONCLUSION

The thanks of the Society and the chairman are due to the various radio stations who made possible the work of this committee, to the committee members for their efforts in behalf of the Society, and, lastly, to the members who gave of themselves in preparing and delivering papers go a special thanks.

Respectfully submitted,
WILLIAM J. STAPLETON, JR., Chairman
W. A. MANTHER
R. H. ALTER.

COMMITTEE ON PREVENTIVE MEDICINE

The Committee on Preventive Medicine has held two meetings during the year; in Detroit in December, and in Lansing on July 12, 1933. A third meeting is to be held in Battle Creek in August.

At the meeting in Detroit Dr. H. F. Vaughan presented the Detroit Plan of Medical Participation in Public Health Work, and Dr. Prichard discussed the plan as operated by the W. H. Kellogg Fund. The plans were discussed by the different members of the committee from the standpoint of problems in their communities.

At a meeting in Lansing, July 12, Drs. Vaughan and Prichard were asked to present a paper on "Medical Participation in Public Health" before the Michigan State Medical Society at Grand Rapids. This paper is to be discussed by Dr. Holmes of Muskegon and Dr. F. B. Miner of Flint.

In discussing medical participation, it was recognized that some agency, either social or public, would of necessity have to be responsible for the operation of such a program. The ideal method would be to have County Health Units, but many difficulties are encountered in obtaining legislation to bring this about. In the meantime it is necessary to contact the State Department of Health, the University, and County Health Units operated under the various foundation; *i.e.,* Couzens, Kellogg, etc.

Members of this committee are making these contacts and will endeavor to work out a plan to present to the House of Delegates in September.

Respectfully submitted,
L. O. GEIB, *Chairman.*

COMMITTEE ON "THE STUDY OF BIRTH CONTROL"

1. Contraception is an important medical aspect of vital importance to the American people.
2. Contraception should be under proper medical supervision and not under the control of the laity.
3. Contraception constitutes an important branch of preventive medicine today.
4. Contraceptive advice and treatment should be given by the family physician.
5. Physicians desiring to give contraceptive advice and treatment should be informed of the most modern and scientific methods, and the Committee suggests that when necessary, further arrangements for post graduate instruction be provided by our State Society.
6. The increase of criminal abortion, which may be conservatively estimated at two million a year in America, would be materially reduced if contraceptive measures were scientifically administered.
7. Contraception would minimize the number of therapeutic abortions in cases where pregnancy should never have occurred because of the presence of serious, organic maternal disease.
8. The committee is reliably informed that commercial exploitation is being conducted by lay persons not properly qualified to give contraceptive advice, and it believes that such exploitation constitutes a menace to posterity.
9. The medical profession, after a period of several years, in which contraception has been largely

under lay administration, should assert leadership in an organized way to control this problem.

10. The committee is most strongly opposed to the giving of contraceptive advice and treatment without a very thorough analysis of the physical, mental, social, and economic status of the applicant, and it further believes that birth control should just as ardently encourage parenthood where it is indicated as it should endeavor to prevent where it is contra-indicated.

11. Your committee, after due investigation and consideration, recommends that the study of contraception should be indorsed by the medical profession of the State of Michigan, and it suggests that a permanent committee be appointed for further research and investigation.

ALEXANDER M. CAMPBELL, *Chairman.*

HOTELS

Ample hotel accommodations are available at the Pantlind, Rowe and Morton Hotels.

The Pantlind Hotel is just across the street from the Civic Auditorium. Its rates are: $3.00 to $5.00 single and $5.00 to $10.00 double.

The Rowe Hotel is two short blocks from the Civic Auditorium. Its rates are: $2.25 to $3.50 single with bath and $3.50 to $6.00 double with bath.

The Morton Hotel is four blocks from the Civic Auditorium. Its rates are from $2.50 up.

ENTERTAINMENT

The Kent County Medical Society will entertain the Officers, Delegates and Members at a "Rhine Party" in the Pantlind Hotel on Tuesday evening, Sept. 12, at 9:30 P. M.

Golf privileges for Blythefield Country Club may be obtained at the Registration Desk.

Parking privileges stickers can be secured at the Registration Desk.

COMMERCIAL AND SCIENTIFIC EXHIBITS

In a most spacious, well lighted and modernly equipped exhibit hall in the new auditorium will be found a splendid commercial and scientific exhibit.

Members are urged to arrange to visit these exhibits. It will be profitable to do so.

COMMERCIAL EXHIBITS

Mead Johnson Company.
Holland Rantos Co.
Gerber's Infant Foods.
Curdolac.
Kuhlman's Surgical Supplies.
Horlick's Malted Milk.
DePuy Mfg. Co.
Professional Underwriters.
Medical Arts Pharmacy.
DeVilbis Co.
G. A. Ingram Co., Surgical Supplies.
Abbott Laboratories.
Medical Protective Co.
H. G. Fisher Co.

SCIENTIFIC EXHIBITS

Dr. German has through his diligence secured an exceptional list of scientific exhibits. They contribute much to the scientific interest of the meeting. Do not fail to see them.

Drs. Lawrence Reynolds and Frederick Schreiber, Detroit, "X-ray Studies of Brain Injuries."

Dr. Claire L. Straith, Detroit, "Plastic and Oral Surgery."

Drs. Ballin and Morse, Detroit, "Parathyroidism."

Dr. Henry L. Chadwick, Detroit, "Tuberculosis in Children."

Dr. F. P. Currier, Grand Rapids, "Movies—Filterable Virus Infections of Nervous System."

Grand Rapids Anti-Tuberculosis Society, "Statistical Data and Graphs."

Dr. G. G. Stonehouse, Grand Rapids, "Intravenous Urograms."

Dr. Leland M. McKinlay, Grand Rapids "Cystometric Bladder Studies."

Drs. Wm. A. and Lawrence Evans, Detroit, "Studies on Malignancy."

Dr. Fred J. Hodges, Ann Arbor, "Subject not announced."

Dr. Alden Williams, Grand Rapids, "Superficial and Borderline Malignancy."

Dr. Vernon Moore, Grand Rapids, "Subject not announced."

Grand Rapids Board of Health, Dr. Edwards, "Milk and Meat Inspection."

Dr. Jarre, Detroit, "Peristalsis of Renal Pelvis."

WOMAN'S AUXILIARY ENTERTAINMENT

September 12: Tuesday Evening

Reception—Mezzanine Floor, Pantlind Hotel.

September 13: Wednesday Morning

Visit to Furniture Exhibits.
Golf.

1:00 P. M. Luncheon at Blythfield Country Club.
Visit to Gardens.

7:45 P. M. General meeting.

September 14: Thursday Morning

Visit to local stores.

Local Committee:
Reception—Mrs. J. B. Whinery
Transportation—Mrs. Vernon Moore
Registration: Mrs. J. N. Holcomb

HOUSE OF DELEGATES

CREDENTIALS COMMITTEE

T. J. Carney, Alma, *Chairman*

L. T. Henderson, Detroit W. C. Ellet, Benton Harbor
H. M. Best, Lapeer L. W. Switzer, Ludington.

LOCAL COMMITTEES

General Chairman—V. M. Moore.

Assistant General Chairman—Don Cameron.

Hotel and Parking—E. W. Schnoor and G. L. Riley.

Monitors for Section Meetings—*Surgery,* O. H. Gillette and Torrance Reed; *Medicine,* Paul Ralph and Joe Whinery; *Eye, Ear, Nose and Throat,* Dewey Heetderks and Robert Laird; *Gynecology,* J. D. Miller and E. B. Andersen; *Pediatrics,* A. R. Nelson and A. M. Hill; *Dermatology,* Ruth Herrick and John Yonkman.

History—C. H. Johnston.

Local Entertainment and Clubs—Frank Doran, Chairman, David Hagerman, William Butler and R. H. Denham; Blythefield, Rowland Webb; Cascade, Arthur Moll; Highlands, William DuBois; Kent, W. A. Hyland.

Committee on Invited Guests: F. N. Smith, R. R. Smith, Alexander Campbell, L. J. Schermerhorn, G. H. Southwick, R. J. Hutchinson, John R. Rogers, V. M. Moore, J. C. Foshee, Rowland Webb, A. B. Smith, H. S. Collisi, John H. McRae, and W. A. Hyland.

SOCIETY ACTIVITY

OUR GENERAL MEETING

On Wednesday evening of each annual session our members and guests convene in a general meeting. At this time there is a general statement made as to the year's work, future plans and the enactments of the House of Delegates.

The retiring president delivers his annual address and imparts valuable recommendations based upon his experiences while in office. The president-elect is inducted into office and briefly outlines his presidential policies.

The retiring president also invites some distinguished person to address those assembled. This year Dr. E. H. Cary of Dallas, Texas, who has just completed his term as president of the American Medical Association, is to be the guest speaker. Dr. Cary will bring much that is sound and applicable.

These features are cited to urge larger attendance at this feature of our annual meeting. Every member should be present to greet and honor those who participate in the program. Plan to do so this year.

KENT COUNTY SOCIETY HEADQUARTERS

Following thirty years of organizational existence the Kent County Society secured its own headquarters. During the previous years its meetings had been held in various local rooms and at the hospitals. With an addition to be erected to the Medical Arts Building the society perceived an opportunity and arranged to lease desirable space in that new addition. Upon the completion of the building a House Committee was appointed to furnish the new quarters. This was done and the accompanying pictures impart the plain yet rich and comfortable furnishings.

CLUB ROOM—KENT COUNTY MEDICAL SOCIETY

The opening night a buffet supper was served and over 95 per cent of the members attended the House Warming. During the evening reports were rendered revealing that some $4,500 had been expended in providing the Society's permanent quarters. The question of payment was answered within an hour when the members underwrote the entire expense and cleaned up the debt—and this was in the early part of 1932!

Kent County members are proud of their club rooms. They invite any doctor to make it his headquarters when in the city. Here you can rest, read, telephone and often join

in a game of bridge. An attendant will be found in charge.

The reading room has a large number of reference texts and most of the current journals. Luncheon will be sent out for if you desire to eat. Without boasting these are credited as being the finest furnished club rooms in the state—Grand Rapids furniture, of course, and that's why!

READING ROOM—KENT COUNTY MEDICAL SOCIETY

RADIO BROADCASTING

Dr. Carl Moll, a Michigan delegate, introduced a resolution related to radio broadcasting which was passed by the House of Delegates of the A. M. A. at its Milwaukee meeting. After a suitable preamble the resolution concludes with:

"RESOLVED: That the Board of Trustees through the Bureau of Investigation and through such other national organizations as the Board may be able to enlist, initiate and pursue activities and efforts to terminate misleading and misrepresenting radio broadcasting that is related to medicinal remedies and preparations for the conservation and protection of the health interests of the public."

A timely resolution. It is hoped that the A. M. A. will promptly and aggressively initiate activity to comply with this resolution and exercise its influence to cause an early cessation of the medical "bally-hoo" that eminates from chains and many stations. One rarely tunes in on any program but what he hears a harangue about some patent preparation and its curative value for a group of ailments. Unwarranted claims and statements are made and the public is deceived by the advice given. Public health is being jeopardized.

It is time to call a halt. These medicine vendors, denied advertising in publications, have rushed to the radio station to advertise their questionable preparations. Broadcasting stations, eager for financial profits, allot time on their programs but apparently exercise no censorship. They seemingly are unconcerned and are interested only in collecting the time rate.

The American Medical Association, aided by certain magazines and newspapers exposed fraudulent magazine and newspaper medical advertisements. The columns of the press and of magazines were cleaned up. The same course should be pursued in cleaning up the advertising that is broadcast on the air by radio.

The A. M. A. cannot accomplish this alone. It requires the assistance of the public and the profession. Adverse sentiment must be aroused and evidenced. Chain and station managers must become aware of resentment and protest from thousands of listeners. Letters of criticism and objection should be sent to these managers by the thousands. Request your friends to send in their objections and write yourself. The air channels of radio must be cleared of

fraudulent, misleading medical statements and drug advertising that is detrimental to public health and welfare.

PHYSICIANS AND STATE SALES TAX

Persistent effort eventually secured the following statement from the Director of the State Tax Board:

Rule 29.—Persons engaged in the professions of and known as opticians and optometrists, physicians, dentists, architects, artists and veterinarians are deemed to be rendering services and not selling at retail. They are considered to render and receive compensation primarily for services, the receipts from which are not taxable. The sale to such persons of such tangible personal property as they may use or consume incidental to the rendering of such services are "sales at retail" the gross receipts from which are taxable.

"Where members of the professions enumerated above, sell tangible personal property to consumers for use apart and distinct from the rendering of a service, they are liable for tax on gross receipts from such sales."

A general interpretation of this rule (unofficial) would be that there is no tax on the fees you receive. If in addition to your fee you supply drugs or supplies and charge for them in addition to your fee, this latter amount would be subject to tax.

ANNUAL MEETING DETAILS

This issue contains the final and official program. Its features should induce the attendance of every member. Grand Rapids bids you come.

Delegates will find the annual reports of committees published in this issue. Familiarize yourself with their recommendations in order that you may record intelligent action.

Delegates will please note that the first session of the House of Delegates is on Monday, September 11, at 2:00 P. M. The Credentials Committee will convene at 1:00 p. m. to pass on your credentials. Every delegate, to be seated, must present credentials signed by the County Secretary.

Be sure to register. Registration Booth will be found in the Exhibit Hall in the Civic Auditorium.

Do not fail to visit the Commercial and Scientific Exhibits. You will find many exhibits of interest and profit. Commercial firms will deem it a favor if you call at their booths. They can help you solve some of your personal problems.

The General Session on Wednesday evening will provide a program of interesting, enlightening and helpful addresses. Plan to attend and invite your friends. Gain a true insight as to the future of medical practice and the responsible rôle of the physician.

The Kent County Medical Society is prepared to aid you so as to enable you to enjoy this annual meeting. Accept their cordial invitation to attend

DOCTORS CHARGE TOO MUCH

They certainly do, there is no doubt about it. We have observed the practice for many years and the charge cannot be refuted. There is no reason for it, any more than there is for lawyers, plumbers, architects or any trade. No just business reason can justify it. There is no sound basis for this practice unless it is the exceptional case. That doctors charge too much is frankly admitted.

In almost every other calling or business a charge for services means payment in thirty days. If a charge credit is extended it is for thirty days, sometimes sixty days, rarely ninety days. A cash payment is the preference, a charge is second and then only for a limited time and that time is printed on the statement that is sent. Why shouldn't doctors apply the same rule?

Yes, you will charge for your services but only for thirty or sixty days. Expect and ask for cash payment, charge as an accommodation but don't be guilty of charging too much or too often. Less charges and more cash payment and you will not be accused of charging too many of your accounts. Doctors charge too much because they fail to cause their patients to learn that they prefer cash payments.

MINUTES OF THE EXECUTIVE COMMITTEE OF THE COUNCIL

July 26, 1933

1. The Executive Committee of the Council held its monthly meeting in Muskegon at the Muskegon Country Club at 6:00 P. M. with the following members present: Doctors Corbus, Cook, Boys, Bruce and Carstens. Also present were President Robb, President-elect Le Fevre, Editor Dempster, Councilor A. S. Brunk, J. B. Jackson and the Secretary.

2. The Secretary presented the financial report, imparting the financial status as of July 26.

3. The Secretary reported upon the arrangements for the annual meeting and the details relating thereto. These were approved.

Upon motion of Boys-Bruce it was decided that the Executive Committee would meet at 10:00 A. M. and the Council would convene at 11:00 A. M. on the morning of Monday, September 11, 1933, preliminary to the meeting of the House of Delegates at 2:00 P. M. that day.

4. The Secretary announced the appointments made by the Speaker of the House for the following committees:

Committee on Economics—W. H. Marshall, Bert U. Estabrook, F. A. Baker, L. G. Christian, C. S. Gorsline.

Committee on the Revision of the Constitution and By-Laws—L. G. Christian, D. P. Foster, W. I. Reveno, L. F. Foster, F. A. Reeder.

5. At the request of the Chairman, J. B. Jackson reported his activities as the Society's representative on the Crippled Children's Commission. He stated that the recent act of the Legislature provided for the care of the underprivileged child and that by the result of that law it was necessary to determine certain medical fees, including fees for satisfactory administration. That a conference had been called for August 14 and that a request was being made to the State Medical Society to appoint a committee to represent the State Society at this conference. After discussion upon motion made by Boys-Bruce, the chair was authorized to appoint a committee. The chair appointed the following committee: J. B. Jackson, Chairman, Kalamazoo; Burt Greene, Hillsdale; Clair L. Douglas, Detroit.

6. The Secretary presented a communication from Councilor Treynor relating to the organization of a corporation to provide health insurance. The communication was discussed and referred to the Committee on Medical Economics.

7. The Secretary informed the committee that he

had endeavored to secure information regarding legislative activities in connection with the statement presented by the Wayne County Medical Society. That he had received some replies but had not yet received a statement from the Legislative Committee. The Chairman moved that without full information the matter could not be considered and would be deferred until the September meeting of the Executive Committee.

8. The Secretary announced the annual conference of State Secretaries to be held in Chicago, September 22 and 23. Upon motion of Bruce-Carstens, the Chairman of the Council and the President of the Society were authorized to attend this conference.

9. The Secretary requested instructions as to whether or not the report of the Legislative Committee should be printed in the JOURNAL in accordance with the instructions of the House of Delegates that all committee reports be printed previous to the annual meeting. He stated that the report would undoubtedly contain much confidential information and questioned the advisability of journal publicity. After discussion, the Secretary was instructed to omit the Legislative Committee's report from the September JOURNAL and to request the Chairman of the Committee to make his report direct to the House of Delegates.

10. The Executive Committee approved the following order of business for the first session of the House of Delegates on September 11.

1. Organization of the House
2. Speaker's Address
3. President's Address
4. The report of the Council
5. Appointment of Reference Committees.
6. Report of the Committee on Medical Economics.

The House will then continue its regular order of business.

11. The Executive Committee and those present devoted considerable time to the discussion of the question that had been raised relative to the release of newspaper publicity at the special meeting in Lansing. After a full discussion it was moved by Boys, supported by Carstens, that the President appoint a committee of three to investigate and make its report to the President.

There being no further business, the Committee adjourned at 11:00 P. M.

F. C. WARNSHUIS, *Secretary.*

COUNTY SOCIETIES

NORTHERN MICHIGAN

The regular monthly meeting of the Northern Michigan Medical Society was held at the Hotel Perry, Petoskey, Thursday, August 10, with an attendance of twenty-two members and eight guests.

The meeting was one of the best ever held by the society in recent years and those who failed to attend missed an excellent program. The meeting was called to order by President Frank, who immediately turned it over to the members of the Program Committee.

Dr. B. J. Beuker, East Jordan, then introduced Dr. Peter Lashmet, Assistant Professor in the Department of Medicine of the University of Michigan. Dr. Lashmet spoke on "The Importance of Adequate Fluid Intake in Treatment of Diseases."

Dr. John Skow introduced the next speaker who was Dr. E. L. Compere, Assistant Professor in the Department of Surgery, University of Chicago. Dr. Compere spoke on the "Decalcification of the Skeleton in Hyperparathyroidism."

Report of the Public Relations Committee was heard.

Dr. James Stringham, Cheboygan, was appointed to the Program Committee.

It was moved and seconded that the September meeting be held on the first Thursday of the month due to the meeting of the State Society the following week. Motion carried.

E. J. BRENNER, *Secretary.*

UPPER PENINSULA MEDICAL MEETING

Some sixty-five members of the Upper Peninsula attended the thirty-sixth annual meeting as the guests of the profession of Escanaba on August 11 and 12. The scientific program was excellent and much credit must be given to Dr. Charles L. Brown of Ann Arbor for his splendid clinics and talks ably and instructively conducted.

SCIENTIFIC PROGRAM

"Demonstration of a Case of Combined Diabetes and Pulmonary Tuberculosis"—Charles L. Brown, M.D., Ann Arbor, Mich.

"Management of Lobar Pneumonia in Childhood"—M. Cooperstock, M.D., Marquette.

"Chronic Infection of the Prostate and Urethra"—Damon A. Brown, M.D., Madison, Wis.

"Traumatic Surgery"—H. S. Brown, M.D., Detroit.

"Spinal Anesthesia"—Frank A. Kelly, M.D., Detroit.

"Consideration of Digitalis, Diuretics and Diet"—Charles L. Brown, M.D., Ann Arbor.

BANQUET

Toastmaster—John J. Walch, M.D.

"The Doctor Forced into Politics"—Mr. William Burns, Detroit.

"Medical Economics Applied to Practice—F. C. Warnshuis, M.D., Grand Rapids.

"Backache"—N. R. Kretzschmar, M.D., Ann Arbor.

"Head Injuries" (Lantern Slides)—F. C. Warnshuis, M.D., Grand Rapids.

"Thyrogenic Heart Disease, Hyperthydroidism and Myxedema"—Charles L. Brown, M.D., Ann Arbor.

It is always a delight to gather with these Upper Peninsula doctors. They reflect a high appreciation of their responsibilities and are sincere in their endeavor to render efficient service. For hospitality they are unexcelled.

It would be remiss to omit mention of Dr. C. J. Ennis of the Soo. Dr. Ennis has always been active in his society, a former Councilor, and a genial soul. Though he will not admit the age, his four score and three years do not retard his activities and his voice was pleasant to listen to in the "wee hours" at the banquet where he was the last to leave.

Members present from other parts of the state were Drs. F. A. Kelly and L. J. Hirshman and Mr. Burns of Detroit. Drs. Curry and McGregor of Flint, Dr. C. C. Slemmons and Karl Brucker of Lansing and F. C. Warnshuis.

Officers elected were: President, John J. Walch, M.D., Escanaba; vice president, F. G. H. Maloney, M.D., Ironwood; secretary—the secretary of the Gogebic County Medical Society will act as secretary of the Upper Peninsula Society.

The 1934 meeting will be held in Ironwood.

WOMAN'S AUXILIARY, MICHIGAN STATE MEDICAL SOCIETY

JACKSON COUNTY

The Jackson County Medical Auxiliary held the last meeting of the year on May 16. It was preceded by a luncheon at the Tea Pot. The president, Mrs. George Seybold, opened the meeting with a few words expressing her appreciation of the coöperation of the members and thanked them for their loyalty.

Reports were given by the secretary, Mrs. M. McLaughlin, and the treasurer, Mrs. E. H. Corley. Committee reports were made by the chairmen of the following committees:

Social Committee—Mrs. F. E. Hackett.

Legislative Committee—Mrs. E. S. Peterson.

Officers for the next year were elected as follows: Mrs. W. L. Finton, president; Mrs. G. C. Hicks, vice-president; Mrs. E. D. Crowley, secretary, and Mrs. H. L Hurley, treasurer. Preceding the luncheon, Mrs. Seybold was presented with a lovely corsage by Mrs. Finton, who expressed the appreciation of the auxiliary for the successful year.

The tables were centered with bouquets of pink and yellow tulips. Bridge was played later.

INGHAM COUNTY

The Woman's Auxiliary of the Medical Society of Ingham County held its annual meeting in May at the home of Mrs. L. G. Christian. A one o'clock luncheon was served after which a short business meeting was held. Mrs. D. A. Galbraith was elected president and Mrs. George Bauch, secretary for the ensuing year.

Mr. William Burns spoke on the laws of vital interest to the medical profession, which were pending in the legislature. Dr. E. R. Vander Slice, head of the City Health Department, told of the ways in which the women of the Auxiliary might coöperate in helping to raise the general health conditions in the city.

The programs for the year have been interesting, the welfare work has been outstanding and the friendliness engendered in the society has been helpful to all.

MRS. CYRUS B. GARDNER,
Retiring President.

QUACKERY, CHARLATANISM AND CULTISM

(Howard W. Haggard, M.D., in *New York State Journal of Medicine*)

"Quackery, or charlatanism, or cultism, is always medicine out-of-date. All the cultism of today is the discarded medical practice of the past and most of it is so far in the past that it goes into the primitive or savage state. If we brought from some South Sea Island or from the forests of Africa a native medicine man and allowed him to practice according to his native rites in our more or less civilized midst—and I have no doubt that he would be allowed so to practice in many of our states, if his foster and more up-to-date brethren in the legtimate profession of medicine could retain their cherished and exclusive privilege of signing the death certificates for his patients—such a man, a savage medicine man, would differ not at all in principles of practise, only in form, from the various cults of charlatanism already supported in our midst, whether they be metaphysical healing, back slapping, foot twisting, or patent medicine. Charlatanism is as atavistic as war—its existence proclaims the fact that civilization is only a veneer. Scratch even the most cultured skin and you draw the blood of a savage. The charlatan does no actual physical good to his patients, yet many people of our public hold him in veneration, the veneration of personal prestige. Those who submit to his ministrations have a stronger emotional feeling for him than for the scientific but frankly less artful physician."

GENERAL NEWS AND ANNOUNCEMENTS

Dr. Henry D. Chadwick, who has been tuberculosis controller for the city of Detroit since 1929, was appointed Health Commissioner of the State of Massachusetts by Governor Joseph P. Ely. Dr. Chadwick will leave Detroit to assume his new duties by the first of October. He has been for many years a resident of Massachusetts, where he was in charge of the Westfield State Tuberculosis Sanitarium.

Dr. Reuben Peterson, professor emeritus of obstetrics and gynecology of the University of Michigan Medical School, has retired from active practice. Dr. Peterson was associated with the University of Michigan Medical School from 1901 to 1931, when he retired from the position of active professor. He was medical director of the University of Michigan Hospital from 1911 to 1918. Dr. Peterson was president of the Washtenaw County Medical Society in 1902 and president of the Michigan State Medical Society in 1915. At the Milwaukee session of the American Medical Association Dr. Peterson was made an honorary Fellow.

Dr. John L. Walsh of Escanaba is president of the Delta County Medical Society and not Dr. L. P. Groos, who was reported as president in this JOURNAL.

Dr. A. V. Forrester and Mrs. Forrester left Detroit on July 20 for two months' sojourn in Edinburgh and Glasgow, Scotland, where Dr. Forrester will pursue postgraduate work in internal medicine.

DR. EDWARD C. DAVIDSON

OBITUARY

Dr. Edward C. Davidson of Detroit died suddenly at his home, Grosse Pointe Park, on August 7, 1933. Dr. Davidson was born at Pittsburgh and was educated at Harvard University and Johns Hopkins, from which latter institution he received his medical degree in 1920. After seven years internship at Johns Hopkins Hospital he became a member of the staff of Henry Ford Hospital, Detroit. He left Ford Hospital in 1925 and went into private practice. Dr. Davidson devoted his attention to the study of changes in the physical organism which accompany severe burns whereby he discovered that the changes which in the graver cases produce death where due to absorption of the toxic substance formed at the site of the burn. He devised a new treatment which has proved successful. Dr. Davidson was a member of the Wayne County and Michigan State Medical Societies and American Medical Association. He was also a Fellow of the American College of Surgeons. He is survived by his wife, Alice, and two sons, Drew and James.